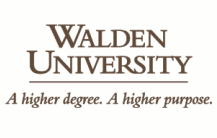

2016

Domestic Violence Intervention Program Facilitators' Motivation for Working With Repeat Offenders

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This is to certify that the doctoral dissertation by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
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Abstract

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MA, Argosy University, 2012

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Dissertation Submitted in Partial Fulfillment

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Abstract

Domestic violence (DV) rehabilitative program facilitators administer the same treatment programs to males who reoffend. When DV facilitators administer the same unsuccessful treatment programs to repeat offenders, facilitators may lose intrinsic and extrinsic motivation to perform their job. For this study a hermeneutic phenomenological methodology approach was used to explore the phenomenon of DV facilitators' motivation. Self-determination theory was used to frame the influence of intrinsic and extrinsic motivation on DV facilitators who administer treatment programs to repeat offending males. A recruitment flyer was placed in the DV organization, data were collected from 7 participants through face-to-face or telephone interviews that were 18 years of age, proficient English speaking, actively facilitating DV treatment programs to repeat offending males, and employed with the DV organization. Data were transcribed and coded using open and axial coding, and analyzed for themes. Findings indicated that accountability, intrinsic motivation, and commitment influenced DV facilitators when administering programs to repeat offenders. Social change implications include awareness of perceived laissez-faire criminal justice policy towards DV male offenders and the lack of community support of challenges and opportunities for enhancing motivation for DV program facilitators.

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Dedication

I dedicate this dissertation to my husband, Kevin Mark Barclay. You are the epitome of support and a powerful leader by example; your love exudes that of a gentle lamb, covenant partner, and one of the biggest cheerleaders a person can ever hope to have. You have relentlessly continued the steady pace of encouragement and never grew weary of hearing about this dissertation. I will never forget the times you stayed awake to make sure the goals I set toward completion were accomplished. I thank you for walking out purpose with me and allowing your actions to mimic your heartfelt words of love toward change.

Acknowledgments

I must begin with giving all honor and glory to Yeshua (Jesus) Christ for guiding and shielding me during this impactful Ph.D. journey, which was one of the most challenging yet rewarding accomplishments of my life. Second, I wish to thank each of the domestic violence facilitators who willingly participated in this study and entrusted me with their lived experiences. Being made aware of their unfathomable commitment and accountability to offending and repeat offending males will provide a continuous progression toward safer communities for women and children, and ultimately realigning the strength of the family unit.

I would be remiss not to mention Dr. Barbara Benoliel, my doctoral chairperson, for providing me with your selfless love, care, wisdom, knowledge, and guidance with a constant reminder of your belief in me. I also wish to thank and acknowledge my committee member, Dr. Tina Jaeckle, for overseeing and believing in my study and supporting the progression of strengthening families and communities, and URR, Dr. Lillian Chenoweth, for your commitment in overseeing this study with a sharp attention to detail. I also wish to thank Dr. William Barkley, whom I adopted as my Walden University Dad; you exude excellence as a leader.

I thank my dad, James Jenkins, for instilling in me the drive to overcome obstacles and never give up on my dreams, no matter how impossible it looked, and my mom, Lucille Jenkins, for teaching me the power of prayer and walking by faith believing the things I hope for will happen. My children, DeShawn, Alayna, Alexis, and Zo'e, for acknowledging the strength and power you all feel I walk in as your mother and always

believing in me, along with your prayers and encouraging words of support, my family, friends, and colleagues. I especially thank Dr. Avon Hart-Johnson, for your sharp attention to detail, feedback, and dependable support.

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Chapter 1: Introduction

Domestic violence (DV) is known throughout the United States primarily for the adverse effects it has on its victims resulting from the abusive behavior of the perpetrators (Trevillion, Oram, Feder, & Howard, 2012). DV is considered a form of abuse that manifests as physical, sexual, and psychological impediments that may cause division, which challenges the strength and unity of the family system (Trevillion et al., 2012). Richards, Jennings, Tomsich, and Gover (2014) found that men are more likely to commit abuse than their female counterparts. Truman and Morgan (2014) suggested approximately 86% of men charged for DV are subsequently incarcerated, are required to pay fines, and are court ordered to attend rehabilitative treatment programs. Truman and Morgan (2014) also noted that when these men are released, some continue this related behavior that may have an outcome of further separating the family unit. For the purpose of this study, the family unit included members who were biologically related or who had fictive kinship because they resided in the same household.

DV facilitators who administer mandated requirements relating to offender sentences conduct rehabilitation programs such as anger management (Bens, 2012). These facilitators observe actions of the offenders and offer training techniques that can be used to "guide actions and help build strategies to help offenders work through their anger and triggers" (Bens, 2012, p. 5). Facilitators are expected to referee these sessions and serve as spectators rather than partakers (Bens, 2012). They also ensure that the "implementation of the treatment program's goals and objectives are met" (Bens, 2012, p. 5). These facilitators may be initially motivated to help DV violators at the outset.

However, there is a possible risk of facilitators becoming demotivated when they see the same men returning to their treatment programs multiple times. According to Cinar, Bektas, and Aslan, (2011), facilitators may lose their motivation to help DV violators.

In this study, I defined *motivation* as the "stimulus that evokes and energizes a person to accomplish a task and may lead to [a person's] sustained performance and behavior" (Cinar et al., 2011, p. 690). There are two kinds of motivation: internal, which is intrinsic and self-perpetuating, and external or extrinsic motivation, which causes initiation, direction, intensity, and persistence of behavior in a person (Vallerand, 2012). Morse, Salyers, Rollins, Monroe-DeVita, and Pfahler (2012) suggested facilitators' burnout reduces individual work-related accomplishments and job effectiveness that resembles the International Classification of Disease, Tenth Edition (ICD-10) diagnosis of neurasthenia, which is irritability associated with emotional disturbance. Kulkarni, Bell, Hartman, and Herman-Smith (2013) elaborated on motivation being altered by high levels of stress and creating barriers for the facilitators to provide high-quality treatment programs for the offenders. Morse et al. (2012) discussed burnout being an obstacle for the DV facilitators, and Kulkarni et al. (2013) suggested high levels of stress prevent the ability to perform job-related tasks. In my search of the current literature, I found no study that addressed the DV facilitators' intrinsic and extrinsic motivation after being exposed to habitual arrest of DV offenders while administering the same treatment program without any signs of rehabilitation.

In this study, I focused on DV facilitator's intrinsic and extrinsic motivation for administering the same treatment program to repeat offending males in the Georgia area.

The different aspects of intrinsic and extrinsic motivation of human behavior have similarities psychologically and socially. In this chapter, I present the problem statement, purpose statement, research questions, nature of the study, assumptions, delimitations, limitations, and significance of this research.

Background of Domestic Violence Facilitators

In this study, I explored the role of the facilitator in the DV programs. Facilitators tend to "mimic a referee by watching the action more than participating in it" (Bens, 2012, p. 5). They also ensure that the "implementation of the treatment program's overall goals and objectives are met" (Bens, 2012, p. 5). In Georgia, DV facilitators must maintain a bachelor's or higher level degree, or a two-year parallel experience. The training for DV facilitators includes direct contact with DV offenders as a lead facilitator, cofacilitator, and group facilitator in programs designed as intervention strategies to reduce recidivism (Georgia Coalition Against Domestic Violence, 2016; Domestic Violence Training, 2011). Georgia facilitators are also certified through 20-40 hour various DV certifications that are approved by federal and state law enforcements for each perspective state, as well as ongoing requirements for continuing education classes that are available through a plethora of organizations (Domestic Violence Training, 2011; Georgia Coalition Against Domestic Violence, 2016).

Statement of the Problem

Stewart, Gabora, Kropp, and Lee (2014) reviewed the Center for Disease Control (CDC) DV-related information and revealed that there was no consistent evidence of effectiveness with DV treatment programs. DV facilitators' motivation may affect their

work with repeat offenders who do not show signs of rehabilitation. If unsuccessful outcomes reduce facilitators' motivation, their commitment to their work may deteriorate, further reducing effectiveness of the DV intervention program. For employees in any organization, intrinsic and extrinsic motivation may improve performance; if motivation is absent, it may stand in the way of employees' progression. With repeated failures of DV clients, it is unclear whether DV facilitator's will continue to have self-determination to carry out their work.

Being motivated is a key factor in the success of employees and his or her organization (Cinar et al., 2011). There are possible stimulators of both intrinsic and extrinsic motivation. For example, "achievement, recognition, added responsibility, advancement, and even work itself can be motivational" (Cinar et al., 2011, p. 691). Although there have been studies using quantitative methodology, a qualitative exploration of the unique features of intrinsic and extrinsic motivation of DV facilitators and his or her work with returning clients may offer insights and benefits to the field.

Purpose of the Study

The purpose of this qualitative study was to explore the experiences of DV facilitators to examine whether self-determination plays a role in their intrinsic and extrinsic motivation while administering the same treatment programs to males who display DV behaviors habitually. This study addressed the gap in the literature that is concerned with understanding facilitators' motivation after administering the same DV treatment programs to repeat offending males. Further, I provided an understanding of

DV facilitators' awareness of their intrinsic and extrinsic motivating factors from working with this population.

Research Questions

Based on the theoretical framework for this study, the research questions (RQs) were as follows:

RQ1: What is the essence or lived experience of DV facilitators' motivation while administering treatment programs to repeat offending males?

RQ2: How do DV facilitators perceive their role and motivation in the workplace?

Conceptual Framework

The conceptual framework for this study was informed by Ryan and Deci's (2000) self-determination theory (SDT). This model presents different types of motivation that provide dissimilar reasons or goals that contribute to an action; intrinsic motivation occurs for enjoyment and interest, whereas extrinsic motivation occurs for the expected outcome (Ryan & Deci, 2000). The focal point of SDT is the intrinsic and extrinsic motivating factors that drive certain behavior. SDT provides the framework for understanding the influence of intrinsic and extrinsic motivation on the behavior of human beings (Ryan & Deci, 2000). SDT provides a means for analyzing the role of choice in intrinsic motivation (Hagger, Rentzelas, & Chatziasrantis, 2013). SDT is notable among the perspectives on choice and provides an understanding of the role of intrinsic motivation (Hagger et al., 2013). Hagger et al. (2013) explained that individuals

feel more confident and competent in their actions when provided with choices. Human service professionals who allow the freedom of choice enhance motivation by the perception of autonomy and awareness that individuals are executing their actions and thoughts (Hagger et al., 2013).

Research regarding the motivation, or lack thereof, of DV facilitators administering treatment programs was not apparent in the current literature; rather, the emphasis has been placed on outcomes of individuals mandated to attend these programs and on the multiple arrests of offenders (Jones et al., 2010). As indicated earlier, this lack of attention leaves a gap in the literature about the problem of understanding DV facilitators' intrinsic and extrinsic motivation while administering the same DV treatment programs to repeat offenders, with no evidence of change. The outcomes for DV facilitators who reamin in an unmotivated state can result in them becoming desensitized to the severity associated with DV sanctions toward their male offender clients. The focus of leading male offenders toward rehabilitation may be skewed, best ethical practices may not be followed, and the process for effective change may continue to decrease (Riel, Languedoc, Brown, & Gerrits, 2014). Truman et al. (2014) elaborated on possibilities of a continually increased mortality rate and habitual arrests for the victims with the lack of attention to the manner in which treatment programs are administered. The research community may not understand enough about DV facilitators' motivation to devise strategies that may contribute to their effective engagement in DV offender rehabilitation.

Nature of the Study

I conducted a hermeneutic phenomenological study (Moustakas, 1994). Qualitative research provided the freedom to explore, interpret, and understand the lived experiences of DV facilitators (Mennicke, Tripodi, Veeh, Wilke, & Kennedy, 2015). I used a hermeneutic phenomenological approach to understand the essence of lived experiences regarding DV facilitators' motivation while administering the same treatment programs to males who are habitually arrested for the same offense (Giorgi, 2012). Using this phenomenological qualitative design, I was able to explore and understand facilitators' levels of motivation.

Assumptions

I assumed that DV facilitators would feel slightly intimidated based on the population they work with and would experience fear of becoming aware of their innermost feelings. Second, I assumed that self-determination theory was the best theory for understanding the phenomenon of intrinsic and extrinsic motivation. Third, I assumed that a hermeneutic phenomenological design was best suited for this study in describing the essence of the lived experiences of DV facilitators.

Scope and Delimitations

I used convenience sampling to recruit participants who matched the criteria from the flyer. Criteria required participants to verbalize their feelings and give a voice to their experiences of intrinsic and extrinsic motivation while administrating a rehabilitative program to repeat offending males. The primary delimitation was the focus on DV

facilitators and not on other facilitators or professionals. Another delimitation was recruiting a purposeful sample to achieve data saturation.

Limitations

Limitations included the clarification of findings from the DV facilitators' individual perspectives and feelings of understanding their role in administering treatment programs. Recruiting a homogeneous sample to reach saturation from a smaller group served as both a limitation and a delimitation by facing a possibility of not providing a representation of the DV facilitator population. This study included private face-to-face and telephone conference interviews. I did not conduct observations.

Significance of the Study

This study contributed to the research community in three ways. First, the knowledge of how DV facilitators remain motivated to administer treatment programs successfully to reform violators may contribute to the reunification of affected family systems. Jones et al. (2010) discussed DV as a perpetual cycle throughout the United States that often results in devastation, isolation, embarrassment, and separation of families. The need for evidence-based DV treatment programs has intensified focus on the design of these programs and the motivation with which they are being presented to offenders (Jones et al., 2010). Jones et al. (2010) determined that repeated abusive behavior and behavioral complexity from the offenders should be explored by defining repeated offenses as committing two or more of the same or similar abusive acts, and by understanding facilitators' motivating factors when administering the same DV treatment program to repeat offenders.

Second, this study contributed by raising awareness of how repeat offending males who engage in the same DV treatment program show no evidence of change. Third, findings from this study may enhance program effectiveness, lower domestic violence sanctions, and reduce the trauma of family members. Kulkarni et al. (2013) determined the exposure to DV offenses without signs of change increases facilitators' powerlessness in dealing with the social service and criminal justice systems. This study provided awareness of this social problem.

Summary

In Chapter 1, I described the study by providing the key components of intrinsic and extrinsic motivation of DV facilitators administering treatment programs to repeat offending males without change. I elaborated on the DV facilitators in Georgia, including their expectations and qualifications. I discussed how 86% of men were set to reoffend. I explained that the research community may not fully understand DV facilitators' motivation to devise helpful strategies that may contribute to their effective engagement in DV offender rehabilitation.

Chapter 2 presents the literature review and research approach. I describe the conceptual framework specific to DV facilitators' intrinsic and extrinsic motivation while administering treatment programs to habitually offending males. I also describe the research methodology and conclude with a summary.

Chapter 2: Literature Review

Motivation is a vital component to the success of employees and their organization. There is a need to understand more thoroughly DV facilitators' intrinsic and extrinsic motivation while administering DV treatment programs to repeat offending males who show no signs of rehabilitation. Research about facilitators' motivation after continual exposure to DV offenders who exhibit the same reoffending behaviors was limited. The purpose of this hermeneutic phenomenological study was to discover, interpret, and explain the perspectives of motivation, development, and wellness held by DV facilitators employed at a DV organization in the Decatur, Georgia area. The second purpose was to determine what, if any, strategies the facilitators were provided with regarding their motivation. In this chapter, I summarize the literature and synthesize the themes related to the study.

Literature Search Strategy

I used numerous sources to conduct the literature review, including the Walden University Library, Google Scholar, and the World Wide Web. I enquired American Counseling Association publications, Criminal Justice Periodicals, Economics and Management, Education, ERIC, American Psychological Association (APA), Psychology and Behavioral Sciences, MEDLINE, Sage Premier and Health Sciences. I enquired PsycARTICLES, PsycINFO, PsycNET, and ProQuest. I also searched ProQuest dissertations, theses and conference papers to gather a detailed understanding of the current literature.

I used the following key words individually and in combination to provide the best possible results: *domestic violence*, *facilitators*, *domestic violence* and *facilitators*, *motivation*, *domestic violence* and *motivation*, *program facilitators*, *concept* and *motivation*, *lack of motivation*, *domestic violence facilitators* and *motivation*, *domestic violence* and *facilitators* and *lack of motivation*, *phenomenological method*, *burnout*, *facilitators* and *burnout*, *men* and *domestic violence*, *treatment programs*, *recidivism*, *self-determination theory*, *intrinsic* and *extrinsic motivation*, *domestic abuse*, *intimate partner violence*, *intervention programs*, *repeat offenders*, *repeat offending males*, *cycle of abuse*, *cycles of abuse and men*, *families* and *recidivism*, *families* and *abuse*, *men* and *abuse*, *male offenders*, *domestic violence facilitators* and *motivation*, *domestic violence* and *facilitator accountability needs*, *acute stress* and *domestic violence assessment*, *hermeneutics*, *batterer intervention programs*, *facilitator cognitive ability*, *domestic violence facilitator* and *cognitive flexibility*, *domestic violence* and *rehabilitation*, *rehabilitation*, *domestic violence prevention*, *family violence* and *fathers*, *high-risk perpetrators*, *job satisfaction* and *domestic violence facilitators*, *occupational stress*, *occupational stress* and *domestic violence facilitators*, *male offender* and *rehabilitation*, *perpetrator programs*, *domestic violence program development*, *domestic violence provider training*, *domestic violence training*, *domestic violence risk assessment*, *domestic violence risk factors*, *society standards* and *domestic violence intervention*, and *workplace and wellness*.

I used current contributions to the field, including older articles relevant to the study when no recent contributions were found. The literature used for this study was

published no earlier than December 31, 2011. I organized the literature using Zotero, a source reference software, and arranged the findings according to the main points in history, and then to the outlining of the current gap in the literature for this study. I used the key words singularly and in combination until the literature appeared repeatedly, letting me know capacity had been reached in my literature search. I organized the articles in the following folders: self-determination theory, motivation, the key concepts of intrinsic and extrinsic motivation, domestic violence (DV) facilitators, nuances of domestic violence and domestic violence treatment programs, and DV male offenders. I then arranged the folders to organize my literature review chapter.

This chapter is organized around key themes identified in the peer-reviewed articles. First, I focus on self-determination theory (SDT), including the key concepts of intrinsic and extrinsic motivation. Next, I address motivation, the roles of intrinsic and extrinsic motivation, domestic violence treatment program policies, and limitations, roles of domestic violence facilitators, DV repeat offending males, and implications for a domestic violence society. Lastly, I provide a review of my research methodology. I conclude this chapter with a summary of the literature.

Conceptual Framework

Several researchers used self-determination theory (SDT) to describe different types of motivation that are determined by different reasons or goals followed by an action (Ryan & Deci, 2000). SDT addresses the key concepts of intrinsic and extrinsic motivation that drives certain behaviors. I was unable to identify literature that addressed how DV facilitators perceive intrinsic and extrinsic motivation. Intrinsic and extrinsic

refer not only to motivation but also the behavior of human beings (Ryan & Deci, 2000). I could not find literature specific to intrinsic and extrinsic motivation as it pertained to DV facilitators' lived experiences of administering the same treatment program to repeat offending males with no evidence of change. For this reason, I investigated what it means to be motivated intrinsically or extrinsically when exposed to the same patterns of behavior. The conceptual framework of self-determination theory was used to explore how intrinsic and extrinsic motivation influenced DV facilitators being exposed to the same stimuli habitually; identifying individuals as repeat offending males provided a verafiable definition of this understanding and perception of implementing a one-size-fits-all treatment program (Cantos & O'Leary, 2014).

When addressing the gap in the literature, I focused on understanding DV facilitators' specific motivation when working with repeat offending males (Riel et al., 2014). Self-determination theory helped to illuminate specifics of how facilitators' intrinsic and extrinsic motivation was a possible risk to them becoming demotivated when they saw the same men returning to their treatment programs multiple times. This framework also assisted in distinguishing the specifics of intrinsic and extrinsic motivation. The data analysis process (as well as the hermeneutic phenomenological method) is explained further in Chapters 3 and 4.

Self-Determination Theory

Deci and Ryan (2008) and Haggar et al. (2013) shared the same views on types of motivation and amounts of motivation, with close attention to autonomous motivation,

controlled motivation, and a-motivation as prognosticators of performance, relational, and well-being results. Deci and Ryan (2008) stated SDT is also used to look at people's life goals or aspirations, showing relations between intrinsic and extrinsic life goals and performance and psychological health. Deci and Ryan (2008) and Haggar et al. (2013) noted that a perceived innate drive of motivation will move an individual toward an action. Ryan and Deci (2000) posed limitations with SDT by not targeting the foundations of the scarcity and needs of mental health. Autonomous motivation, controlled motivation, and a-motivation are examples of this perception. Ryan and Deci (2000) influenced this study by supporting the SDT theory, claiming intrinsic and extrinsic types of motivation distinguishes between developmental and educational practices. This means that the person is moved to do something (Ryan & Deci, 2000). The nature of SDT is the motivation that encompasses all areas of activation such as energy, direction, persistence, and an end state that can be reached by multiple means (Ryan & Deci, 2000). Paying close attention to the specifics of intrinsic and extrinsic motivation leads to the foundational truths of SDT (Ryan and Deci, 2000). These foundational truths are encompassed in the overall well-being in health care. Ng et al. (2012) used SDT through the lens of health care, noting that health promotions are vital to a balanced life. Ng et al. (2012) also stated that SDT can be used in the health care arena to loo into the constructs and outcomes of behavior when facing significant changes.

Motivation is extremely valuable due to its production of consequences and its importance to DV facilitators who are responsible for mobilizing others to act (Ryan &

Deci, 2000; Lee et al., 2014). Researchers made assumptions and comparisons between people who authentically function in self-authored motivation and those who are controlled externally for an action (Haggar et al., 2013; Lee et al., 2014; Ryan & Deci, 2000). Ryan and Deci, (2000), Haggar et al. (2013), and Dysvik, Kuvaas, and Gagne (2013) are foundational in acknowledging and identifying the depth and breadth of intrinsic and extrinsic motivation.

Ryan and Deci (2000) stated that individuals experience the quality and performance of intrinsic and extrinsic motivation very differently. However, Cinar et al. (2011) stated the focus is on the motivation of the expectation of the outcomes. To further delineate on the key concepts of SDT, Ryan and Deci (2000) and Oostlander, Guntert, Van Schie, and Wehner (2014) discussed the second set of concepts taken from the self-determination continuum, which outlines different types of motivation, regulatory styles, and the locus of causality and corresponding processes. Dysvik et al. (2013) stated to understand SDT there is a psychological need for satisfaction with the anticipation of motivation intrinsically. The concepts of motivation that informed this study are intrinsic motivation, extrinsic motivation, a-motivation (the absence of intending to act), situations associated with DV facilitators' motivation, the perception ascertained by others, and psychological and physiological motivational needs and health as an energizing state of being (such as innate, essential, and universal). There was limited research addressing the application of intrinsic and extrinsic motivation in the DV facilitator population, and no studies were found that relate to DV facilitators' experience of being faced with administering the same DV treatment program to repeat offending males; with no signs

of being rehabilitated. This study extended the understanding in this area by providing insight into DV facilitators' motivation after exposure to the lack of rehabilitation in repeat offending males who were administered the same DV treatment program.

The most important presupposition in speaking about the exposure DV facilitators face was exploring their intrinsic and extrinsic motivating factors and understanding the function these factors have towards the actions of human beings. Haggar et al. (2014) belief is with SDT intrinsic motivation being a prominence of social psychological perspectives of choice. Having to detail SDT, issues relevant to intrinsic and extrinsic motivation with DV facilitators' core experiences could demonstrate a relationship with the behavior of DV facilitators'. Intrinsic motivation refers to the internal and self-perpetuating actions such as the doing of activity, as well as the relationship between individuals and activities (Cinar et al., 2011; Ryan & Deci, 2000). SDT describes intrinsic motivation as being identified as the natural tendency and very critical to cognitive, social, and physical development (Cinar et al., 2011; Ryan & Deci, 2000). There is a sense of satisfaction a person gains from operating intrinsically with a task engagement. Extrinsic motivation encompasses the external and cause of behavior with a person (Vallerand, 2012). Motivation is activated through the prospect of gain and loss and when there is a separate outcome such as attaining other things of value (Cerasoli, Nicklin, & Ford, 2014). In other words, Cerasoli et al., (2014) outlined the extrinsic motivation of SDT occurs when there is a separate outcome provided, or relied upon; a sense of a carrot on a stick and the performance is conducted to receive the expected outcome. Because of this assumption, intrinsic and extrinsic motivations are indeed in

contrast with one another, but necessary for the balancing of great achievement in the workplace (Cerasoli et al., 2014). DV facilitators are expected to administer treatment programs to repeat offending males with sanctions of some form of a domestic violent act towards another; without signs of change. Kulkarni, Bell, and Hartman (2013) reported facilitators exposed to client secondary trauma stress can leave feelings of having little control over their work and also compromises the ability for the facilitators' to attend solely to the offenders rehabilitation. Interestingly, Wehmeyer and Abery (2013) suggested self-determination construct is a complex process, which the highest goal was to obtain personal control over one's life and the individuals' perception of the area of control as important. This researcher can see with the exposure to this phenomenon, the DV facilitators having a lived experience through their dialogue. In providing a deeper understanding of what intrinsic and extrinsic motivation is with human behavior, this study interchangeably used the organismic integration theory of taxonomy of motivational types and a taxonomy of human motivation (Cinar et al., 2011; Paydayachee, 2012; Ryan and Deci, 2000). These authors also suggested intrinsic and extrinsic motivations are two perspectives that are necessary to analyze and understand motivation and behavior in any organization. The explanation provided for models of taxonomy of motivational types and taxonomy of human motivation assisted with understanding the different forms of motivation and the contextual factors that either promote, or hinder behaviors. These models also served as a significant part of the study's conceptual framework of self-determination theory (SDT); as I worked towards understanding the essence of the lived experiences of the DV facilitators' motivation

while working with repeat offending males, provided an awareness of being exposed to a habitual phenomenon with the expectation of administering the same treatment without any signs of change. While Ryan and Deci, (2000), Cinar et al., (2011), and Paydayachee, (2012) models informed my conceptual framework, there remained unanswered questions of the lived experiences of DV facilitators' motivation while administering treatment programs to repeat offending males and how their roles and motivation in the workplace are perceived. I wanted to understand from the DV facilitators their perspective of the motivation of having to administer the same thing, to the same people, and then expecting different results. The section below begins with exploring the literature precisely to intrinsic and extrinsic motivation, while revealing the strengths, limitations, and the gap that initially led to the need to conduct this self-determination theory study.

Impacts of Intrinsic and Extrinsic Motivation on DV Facilitators

Most theories of motivation reflect a singular approach, yet it is necessary to include both the intrinsic and extrinsic factors, which encompass the underlying attitudes and goals that give rise to action (Ryan & Deci, 2000). Intrinsic is important phenomena and results in high-quality learning and creativity. Being extrinsically motivated towards an action has a dual nature according to SDT (Ryan & Deci, 2000). This dual nature is described as performing a job task with "resentment, resistance, and disinterest," or, with an attitude of willingness, that reflects an inner acceptance of the value of job-related tasks (Reiss, 2012; Ryan & Deci, 2000, p. 55). As mentioned in Chapter 1, intrinsic and extrinsic motivations are vital to understanding the essence of DV facilitators' motivation

while administering DV treatment to repeat offending males. Looking at intrinsic motivation defined as the doing of activity for its innate satisfactions, and not for any external pressures, or rewards (Reiss, 2012; Ryan & Deci, 2000). Intrinsic motivation is identified as very crucial developmentally through cognitive, social, and physically because it assists with a person growing in knowledge and skills (Cinar et al., 2011; Reiss, 2012; Ryan & Deci, 2000). Also, behavior is measured intrinsically through free choice and self-reports of interest and enjoyment of activity (Reiss, 2012; Ryan & Deci, 2000).

It was interesting how Ryan and Deci, (2000), Reiss, (2012), and Park and Word, (2012) all suggested human beings are liberally brilliant, or self-determined to react at the highest level of reflection and participate with an awareness of choice, with intrinsic tendencies and express only under specific circumstances. Although intrinsic motivation is very important to the development of human beings, extrinsic is just as important in meeting the demands of social roles, which requires responsibility for non-intrinsically tasks. For example, DV facilitators are required to have specific training required to function in this role. The specifics of these roles are discussed later within this study. Meeting the needs of the plethora of DV sanctions, DV facilitators are expected to facilitate the different DV groups replete with repeat offending males. What is presented to the group is in contrast with what is felt internally, yet there is an expectation to perform duties outlined in the job description of a DV facilitator. Extrinsic motivation is autonomous to a great degree, externally assist a person to be motivated to complete a task without pressure and wanting to carry their duties out on their own. Remaining

parallel with SDT, intrinsic fosters the internalization and integration of values and behavioral regulations with extrinsic motivation. Internalization is the process of taking in, and "integration is the process by which individuals transform the regulation (task) into their own, which will emanate from their sense of self" (Ryan & Deci, 2000, p. 60). A similar comparison is drawn from roles of intrinsic and extrinsic motivation model of achievement where goals are looked at as predictors of increased work effort (Dysvik, & Kuvaas, 2013). Again, providing literature that looked at the perspective of intrinsic and extrinsic motivation globally is how Dysvik & Kuvaas, (2013) chose. Dysvik & Kuvaas, (2013) also used the SDT to exert an explanation of work motivation from the employees. However, this is a clear discussion of understanding how intrinsic and extrinsic motivation is needed to create a sense of belongingness and connectedness to the facilitating group.

Dysvik & Kuvaas, (2013) explored intrinsic and extrinsic with increased work from three of the largest Norwegian service organization totaling 1441 employees. The results showed the relationship between intrinsic motivation and an increased in work effort is more positive for the employees that attained high levels of mastery of their specific jobs (Dysvik & Kuvaas, 2013). For example, if DV facilitators had an increase in treatment programs, intrinsically there would be a positive outcome towards their jobs, as long as they maintained a thorough understanding of their position and were functioning at the highest capacity. However, using extrinsic motivation was not viewed as a necessary construct to intrinsic, and organizational restrictions prevented the theorists from collecting additional data, therefore leaving a gap in the literature of how extrinsic

motivation is just as important as intrinsic motivation and necessary when applying SDT research. This literature was chosen to further this study to understand the DV facilitators' perspective of motivation towards their work tasks; even when there was no evidence of change. The question that continued to arise throughout this study was the understanding of extrinsic motivation being a construct and viewed separately of intrinsic motivation towards an outcome to attain (Park et al., 2012; Reis, 2012; Ryan & Deci, 2000). The outcome speaks to how intrinsic and extrinsic motivation simultaneously occurs in human behavior that provides feelings of satisfaction, which permeates through their inner self, as well as through the work assigned to do. Ryan and Deci, (2000) reported operating in basic psychological needs, if intrinsic and extrinsic motivation is essential to the facilitation of an environment it can lead toward a positive change.

According to Cho and Perry (2012) their study focused on researching the influence of intrinsic motivation on employees' attitudes and exploring managerial trustworthiness, goal-directedness, and extrinsic reward. Also mentioned above, these theorists used the SDT for the explanation of intrinsic and extrinsic motivation. DV facilitators are unaware of the behavior that may present within the repeat offending male groups, yet are expected to carry out court-mandated treatment programs towards rehabilitation. There are guidelines set that must be adhered to throughout the treatment program. However, there are no guarantees of positive outcomes. Although Cho and Perry (2012) study used data from 2008 Federal Human Capital Survey (FHCS), which was inclusive of the U.S. Office of Personnel Management (OPM), this study relied on secondary data which prevents a more precise specific of measures and only relying on

data from 2008 FHCS. The literature has demonstrated a defining quality of intrinsic and extrinsic motivation and DV facilitators need to balance with both towards a sequential outcome. Mentioned in chapter 1, DV facilitators are vital to the rehabilitation process of repeat offenders, and there is a possible risk of them becoming demotivated when they see the same men returning to their treatment programs multiple times.

Motivation

The art of motivation is reflected through the willingness of maintaining applicable efforts towards program goals (Brunie, Wamala-Mucheri, Otterness, Akol, Chen, Bufumbo, & Weaver, 2014; Gray, Lewis, Mokany, & O'Neil, 2014; Suri, Sheppes, Leslie, & Gross, 2014). Remaining parallel with intrinsic and extrinsic motivation and both being vital to balanced behavioral outcomes in the United States, Brunie et al., (2014) explored the global aspect of the Uganda community health workers motivation to work with all facets of community services. Some of these services were family planning, domestic violence, outpatient care, contraceptive methods, and mobilizing communities with surgical camps. This particular study and the significance of motivation being prevalent to understanding DV facilitators' exposure to challenging working conditions was not only in the United States but also in other countries. This study drew upon Brunie et al., (2014) acknowledgment of the community health workers (CHW) motivation and level of activity. DV facilitators are also identified as community health workers. Community health workers are expected to provide a service towards a positive change that will positively influence the macro familial copious. These researchers utilized a mixed method in hopes to capture several factors of the facilitators'

performance with their responsibilities, highlighting weaknesses in infrastructure, and logistics support (Brunie et al., 2014). Although these factors of facilitators' performances are important when assisting the community, the inconsistencies of shortages in supplies and lack of support in the workplace hinders a productive outcome. Even with some percentage of support from the community, this was not enough for the proper motivation to provide productive care (Brunie et al., 2014). DV facilitators are faced with repeat offending males sanctioned with various facets of domestic violence acts. There are some males that have made a choice to go through the motions of the treatment program, only to be cleared of their court-ordered charges, and return to their chosen way of life; without a desire to change their negative behavior. Added frustration, Brunie et al., (2014) reported if facilitators are experiencing personal abuse, they are required to use their personal finances towards transportation costs and a reduction in pay to properly care for their families. While noted, countertransference may occur within the facilitation of DV treatment programs. Quantitative and qualitative results show the relationship with the community, yet the recognition of employees' worth across programs was not taken into consideration. Subsequently, further research is needed in the quality of care and concern for the facilitators' motivation to provide adequate care for those in need.

With understanding, this challenge of being intrinsically and extrinsically motivated to facilitate a DV treatment program is just as important within the United States, yet insights were gathered from Gray, Lewis, Mokany, and O'Neil (2014) where their focus was centered globally in New South Wales, Australia. These authors looked

into the effectiveness of domestic violence groups' behavior change and not the experience of the facilitators' involvement during this process. Motivation was a portion of the focal point from the offenders' perspective and not the facilitators (Gray et al., 2014). The lack of motivation from the facilitators, served as a catalyst for the need for this study. Attrition and lack of motivation towards developing a program that works proved the lack of gain towards a positive outcome (Gray et al., 2014). Motivational factors and self-regulation are needed to increase feelings in a useful manner with DV facilitators. Tamir, Bigman, Rhodes, Salerno, and Schreier (2015) discussed the expectancy of self-regulation towards motivation in a useful manner. This study rendered depth into individuals being motivated to act with an increase of feelings of expectation, which generated increased levels of motivation (Tamir et al., 2015). On a personal level, motivation can assist a person with achieving a difficult task, such as laying one's feelings aside and focusing on a better outcome for others. It is imperative to explore the motivation that drives helping professionals. In other words, if motivation can be coerced it can promote prosocial behavior. In this study, I sought to understand the essence from the facilitators' perspective how motivation is the key to projecting a positive outcome, and how does coercing fit into the bigger scheme of things? Therefore, further exploration of motivation provided a greater need for this study of understanding the underline perspective of intrinsic and extrinsic motivation through self-determination theory (SDT). Persuasion and motivation are another study I sought to understand.

In this study, Suri et al., (2014) used the SDT model to have a greater impact when placed at the point of choice and positive messages, promoting autonomy that

resulted in motivated behavior. The method of stair climbing symbolized the mastery of the current level and moving to the next, with motivation being the driving force (Suri et al., 2014). These researchers sought to emphasize autonomy that created greater intrinsic motivation towards positive behavior. In contrast, not being able to measure the long-term effects of manipulation towards a motivated behavior prevented DV facilitators from performing with the motivation needed when serving the community towards a positive social change. To explore further into SDT, understanding intrinsic and extrinsic motivation are two contrasting factors that are necessary for motivated behavior.

Strengths for this study indicated emotions can be cultivated by motivation; potential emotion motivates individuals, and emotion-outcome may shape more adaptive behavior towards positive motivation acts (Tamir et al., 2015). In contrast to emotions being cultivated by motivation, the gap indicated testing the generalizability of motivation for a positive outcome with facilitators' emotions.

Domestic Violence Facilitators

Mentioned in Chapter 1, DV facilitators contributed to structure and process, so the groups can function effectively and make better choices (Bens, 2012). DV facilitators are individuals who understand common objectives, achieving these objectives with the offenders during the rehabilitation process, and understanding how important it is to do this without including any biases (Bens, 2012; Trevillion, Howard, Morgan, Feder, Woodall, & Rose, 2012). The role of facilitator came to fruition during the twentieth century when theorists understood the need for individuals that operated in a leadership style conducive to providing structure to challenging group interaction, versus providing

directives (Bens, 2012). The unique function of facilitators was not to control the process during the group, but was instead to focus on the manner in which the meeting was being ran (Bens, 2012). Truly understanding facilitation and the manner in which this was to be conducted with DV offenders must be strategic.

Providing clarity on what facilitation is will enhance the understanding of what a facilitator is, according to Bens (2012). Facilitation is a form of leadership where the outcome is by the member within the group (Bens, 2012). This leadership allows the facilitator the autonomy to have a focal point of structured effectiveness and collaboration, conducive for the group. As mentioned in Chapter 1, facilitators function as referees, and not so much as players, during the rehabilitation process (Bens, 2012). Stover and Lent (2014) felt it necessary to delve into the DV facilitators training in a variety of ways such as the safety aspects, and the developmental and clinical issues that are faced by DV families. Stover et al., (2014) indicated there are no national standards for providers, at any level, from DV advocates to "batterer interventionists, to clinicians that are required to complete a set amount of hours in most states" (p. 117). In most states, advocates and facilitators are utilized from a volunteer-based workforce (Stover et al., 2014). DV agencies and organizations share the responsibility to keep all involved, safe, and protected. For the success of this protection, implementation of effective DV treatment programs, and effectively assists during the rehabilitation process, extensive training must occur not just with the professionals, but the volunteers (Stover et al., 2014). According to Stover et al., (2014) there were no identified standard outlined for training, degree recommendation, nor required certifications to work with DV offenders

in some states. Batterer intervention programs were mainly court-mandated, which forces the states to develop and adopt legal codes that provide some guidelines for necessary qualifications (Stover et al., 2014).

The chosen methodology was consensus cases where all levels of training were reviewed (Stover et al., 2014). The strengths of this study brought awareness of the need for all helping professionals required to work with the DV population in treatment programs, should be required to be a participant of crossed training, and to cover all areas of DV (Stover et al., 2014). With the need for additional DV training, the limitation outlined for facilitators was transitioning into this training. There may be difficulties for organizations and agencies to adhere to these standards due to funding limitations, which will result in an increase of salaries for the overall transitioning phase (Stover et al., 2014). The significance this article provided for the need of my study was understanding the conditions DV facilitators are faced with, yet required to administer effective DV treatment programs and to look into the motivation of these requirements were not researched. It is vital to understand facilitators must remain neutral when providing tools and rules for the offenders in a group setting, towards any form of DV rehabilitation (Bens, 2012; Trevillion et al., 2012).

In a DV group setting, facilitators are court-mandated to administer DV treatment programs to repeat offending males with concentrating on exploring the acceptability of routine investigation of the offense and from the perspective of the facilitators' experience with DV (Trevillion et al., 2012). These authors gleaned their study from the amount of advocating for policies of abuse and the healthcare perspective of exposure to

the complex link between DV and psychiatric morbidity (Bens, 2012; Trevillion, et al., 2012). This study's aim explored the acceptability of DV investigation's and the responses from the DV facilitators (Rose et al., 2011; Trevillion et al., 2012). The theorists' manner of approach in obtaining this information was conducted through interviews with 24 health service users and 25 professionals. The results provided an understanding that all health servicers felt it acceptable to continue the inquiry about DV in mental health settings, and a small minority of professionals did not (Trevillion et al., 2012). Positive experiences of help-seeking were described from service users, as receiving acknowledgment for the act of abuse and support for needs being met, negative experiences, including non-validation of responses, discrimination, and an absence of support. The strengths of multiple studies provided the awareness of difficulties in assessments and managing DV reporting requirements, and unclear referral lines of communication (Rose, Trevillion, Woodall, Morgan, Feder, & Howard, 2011; Trevillion et al., 2012;). Trevillion et al., (2012) study was limited in understanding if the official investigation was acceptable to service users and clinician, which furthered caused limitations with responses regarding DV from the clinicians, and with a lack of understanding to articulate a precise care and the pathway of the referral process for the initial contact (Trevillion et al., 2012). This article proved a strong relevance for this study because there was a gap in the literature from the DV facilitators' perspective of intrinsic and extrinsic motivation towards repeat offending males. Although the perspective of the clinicians was gleaned, it was from the aspect of the referral pathway and not from a motivating stance. Rose et al., (2011) study was very similar, however,

they went a step further to explore not only the disclosure of DV with facilitators but also the training of professionals in how to properly address DV to increase confidence was explored. Strengths identified with these theorists were the awareness of fear which may lead to further violence from the offenders and the emphasis on the diagnosis may act as a barrier to further investigation by a supportive and trusting relationship between the offender and professional (Rose et al., 2011). The approach used by Nyame, Howard, Feder, and Trevillion, (2013) and Leppakoski, Flinck, Paavilainen (2014), indicated that having the right attitude, knowledge base, and preparedness to responding to DV was beneficial.

Nyame et al., (2013) and Leppakoski et al. (2014) offered the understanding of DV cases going undetected by professionals in South London and Sweeden. Choosing this article provided an understanding of these challenges being global, as well as in the United States. The Physician Readiness to Measure Intimate Partner Violence Survey was conducted, using 131 professionals in Nyame et al., (2013) and utilizing a longitudinal study between 2008 – 2012 for Leppakoski et al., (2014). The findings were conclusive of the lack of knowledge with support services, and inadequate referral resources (Nyame et al., 2013). The limiting factor of these studies was the lack of participation and preparedness for facilitators, and the strengths were the need to implement additional DV training programs that place an emphasis on facilitators' knowledge (Kappakoski et al., 2014; Nyame et al., 2013). DV facilitators' role in the workplace, as discussed above, can be daunting which can result in some forms of burnout and stress.

Although this study was not focused on DV facilitators' burnout and stressful factors, I deem it important to indicate this as additional information towards vindicating the necessity for my study on facilitators' intrinsic and extrinsic motivating factors while administering DV treatment programs to repeat offending males; with no signs of rehabilitation. Morse, Salyers, Rollins, Monroe-DeVita, and Pfahler, (2012), and Kulkarni, Bell, Hartman, and Herman-Smith (2013) informed both studies of the importance of examining burnout being a problem in the mental health field. DV facilitators are a part of the mental health field and as discussed earlier, are faced with various levels of burnout. Two critical areas were the occurrences and the range of undesirable outcomes for staff, organizations and agencies, and offenders (Morse et al., 2012). Burnout can be likened to a domino effect that begins with emotional exhaustion, depersonalization, and reduced personal accomplishment (Morse et al., 2012). Emotional exhaustion is identified as feelings of being extremely fatigued. De-personalization or cynicism refers to having a negative attitude toward the consumers, or clients and work, and negative self-evaluation of the overall job effectiveness (Morse et al., 2012). Burnout can be correlated with other mental health limitations such as depression and can resemble the ICD-10 diagnosis of job-related neurasthenia (Morse et al., 2012). The method Morse et al., (2012) used to add to the world of research was conducting interviews and a pretest-posttest with community health workers from various community mental health centers. As a result of Morse et al., (2012) the controlled study reported an increase in two interventions showed positive to reducing burnout. However, the limitations to the care of the agencies own mental health workers were neglected, and

methodological limitations were inclusive of small samples, samples of convenience, and high attrition rate (Morse et al., 2012). The outcome for Kulkarni et al., (2013) using a person-environment fit model, highlights the compatibility between the characteristics and an individual's work environment for stress. Secondary traumatic stress was also experienced among DV facilitators according to Kulkarni et al., 2013. This survey measured the DV facilitators' perspectives of the workload, control, reward, community, fairness, and organizational values (Kulkarni et al., 2013, p. 114). The finding of this study was the more experienced the facilitator was, the greater level of compassion satisfaction was accomplished, however in contrast, there was little attention to the wellness within the professional (Kulkarni et al.,2013). With all the entities discussed thus far of the facets of DV facilitators motivating factors, providing an understanding of the actual administration of the DV treatment programs will bring additional clarity to the exposure DV facilitators are faced with.

Administration of DV Treatment Programs

DV behavior looks different for many offenders that choose to resolve issues in a way that prohibits another person to function within their autonomous self. Cantos and O'Leary (2014) have generalized how a one-size-fit-all treatment program was not conducive, nor was it logical to administer; with an expectancy of reducing repeat offending behavior. This study looks into a list of issues that should be taken into consideration when exploring evidenced-based intervention programs. Men that are sanctioned for DV behavior were usually mandated to attend a treatment program for DV as a part of the community response (Cantos et al., 2014). It is noted by Cantos et al.,

(2014) that approximately 5% - 20% of the offenders, and in some instances increase recidivism rates. This study used a Duluth-type intervention that which encompasses law enforcements, criminal and civil courts, and human service providers working together for the safety of all communities (Cantos et al., 2014). Power and control theory was the driving standard for this model. However, these standards have failed to incorporate any substantial research evidenced-based on the characteristics of male offenders and the multi-faceted nature of DV (Cantos et al., 2014). Viewing many longitudinal case studies in local and global areas such as Canada and Spain is considered to administering DV treatment programs. Strengths for this study looked into the severity of behavior along with the interventions. The aim of moving clients, or offenders into contemplation and reducing physical aggression and manipulative parenting styles may increase the likelihood that batterers will reduce their abusive behavior, during the administering of treatment programs (Cantos et al., 2014). Cantos et al., (2014), Mennicke et al., (2015), and Veeh, Wilke, and Kennedy, (2015) agreed the limitations identifying variability among offenders' aggression and evidence suggests the one size fits all treatment approach is non-effective. It is very important to create treatment programs that take into consideration all the different ways a person chooses to act in an abusive manner. Along with the need for strategic DV treatment programs, Cantos et al., (2014); Mennicke et al., (2015) and Veeh, Wilke, and Kennedy, (2015) also agree with the effectiveness of an in-prison DV treatment program called STOP and Change Direction.

These researchers looked at STOP and Change Direction treatment program as a way of decreasing the levels of criminal thinking, increase a positive thought process

towards women, and reduce general recidivism rates for the men who completes the treatment program at least once (Mennicke et al., 2015). The acronym STOP and Change Direction stands for survey, think, options, and prevention and the intervention was conducted through a 20-week program consisting of weekly group and individual sessions (Mennicke et al., 2015). The North Carolina prison uses this treatment program since 2001, with no reported changes throughout the years (Mennicke et al., 2015). The areas of focus are "psychoeducation on DV, personal responsibility and accountability for violence prevention, issues of power, control, and equality in intimate relationships, improving communication, and healthy relationship" (Mennicke et al., 2015, p. 470). The goals of this program are reducing attitudes towards DV and the prevention of being re-incarcerated.

Mennicke et al., (2015) used pretest and posttest surveys with 176 individuals and a quasi-experimental sample of 506 offenders over a 5 -7-years re-incarceration. Strengths showed participants improved in their attitudes against women and decreased in their criminal thinking (Mennicke et al., 2015). A true control group was not used in this evaluation, therefore concluding that the STOP program was not effective with male offenders that choose to re-offend (Mennicke et al., 2015). Along with Mennicke et al., (2015); Murray, Chow, Pow, Croxton, and Poteat (2015) looked to understand the administration of DV treatment programs through technology-based applications necessary in this 21st century. Looking into the safety planning to address technology related risks have grown over time and incorporated in DV agencies (Murray et al., 2015). Using a survey of 471 participants for a readiness based program that has practice-

relevant research for practitioners, was the method of choice (Murray et al., 2015). This technology holds promise due to it being cost efficient, accessibility, and the potential for obtaining information quickly. DV facilitators should have the necessary tools to administer effective programs, yet research continues to exemplify this was not so (Murray et al., 2015). There appears to be a disconnection identified as a domestic violence research-practice gap between the research findings and the actual delivery of services (Murray et al., 2015). In contrast, there is a need to strategize for a better use of technology current and the future (Murray et al., 2015). The need to administer effective DV treatment programs is not just a challenge for DV facilitators within the United States, but also globally.

European views of evidence on the effectiveness of DV perpetrator programs were studied by Akoensi, Koehler, Losel and Humphreys (2012). These theorists used old archived journals that specialized in DV perpetrator programs. There appeared not to be any findings of strengths, yet this study yielded a lack of evidence of data on program completion and resulted in not providing definitive conclusions (Akoensi et al., 2012). DV is a very sensitive subject, and the steps used towards rehabilitation must adhere to viewing all areas, not to perpetuate the cycle of destruction, but to strategize specifically to put a halt to this and begin to reduce repeat offenders. This article was chosen to outline further the importance of exploring the intrinsic and extrinsic levels of motivation with DV facilitators, by getting a clearer understanding of the expectations that are required of them to administer a DV treatment program to repeat offending males; yet without any significant evidence of change. As discussed above, this expectancy is not

just in the United States, but also globally. The actual offenders that are sanctioned to be a participant of DV treatment programs can be inundated with so many other factors that they may, or may not be open to unlearning negative learned behavior.

Domestic Violence Repeat Offending Males

As mentioned in Chapter 1 approximately 86% of men charged for DV are incarcerated, pay fines, and court-ordered to attend rehabilitative treatment programs (Truman & Morgan, 2014). Richards, Jennings, Tomsich, & Gover, (2014) reported repeat offenders are defined as individuals whose behavior mimics the same abusive act two or more times and are mandated by the attending Judge to participate in the same specified DV treatment program. Cantos et al., (2014) and Rettenberger et al., (2013) noted the existence of different types of male offenders of DV, with overlapping categories. The categories are family-only aggressive, antisocial, generally violent, and borderline dysphoric, or what is now diagnosed ICD-10 as borderline personality disorder; code F60.3. Generally, men that are violent, or partner-only violent have different characteristics such as lifetime history of conduct disorder, delinquent behavior, behavioral disinhibition, lifetime psychological abuse of intimate partners, and family of origin violence (Cantos et al., 2014; Rettenberger et al., 2013). This study further elaborated on men that are categorized as generally violent was known to have lower rates of completing the DV treatment program, and family-only violent men were much more likely to re-offend (Cantos et al., 2014). This researcher further discussed the more volatile the men were would make it easier for criminal justice and community staff facilitators to classify these men without a need for training in psychological assessments

(Cantos et al., 2014, p. 212). Cantos et al., (2014) and Rettenberger et al., (2013) using a Duluth-based intervention scale, discovered men that will re-offend are the ones that were known as generalized aggressors. The strengths outlined in this work were understanding the various categories of abusive behavior, which required varies treatment programs, and the identified gap was understanding which type of aggressive men are, to be able to curtail a program specific to the needs for reducing recidivism (Cantos et al., 2014). Alcohol and drug use was also a factor in abusive behavior with the male population. This researcher indicated there were 8-11 times of a greater chance of abuse during times of intoxication (Cantos et al., 2014). When viewing DV from the male population perspective, anger arises from feeling frustrated when attempting to recover contact with the attachment figure (Cantos et al., 2014). To provide more clarity, some men violent behavior was a form of protest to reconnect with the person they feel attached to and when this does not occur, abusive behavior arises (Cantos et al., 2014).

Men are more likely than not to demonstrate this behavior as an adult (Cantos et al., 2014; Richards et al., 2014). Therefore, to apply a one-size-fits-all treatment program proves through this research study to be ineffective and the need continues to rise for change. DV facilitators are faced with this often with the expectancy of change. However this does not always occur. Richards et al., (2014) conducted a 10-year analysis of males rearrested for DV and expounded upon men with both re-arrest for DV and nondomestic violent crimes. These theorists looked into risk factors such as demographics, offending history, age, marriage, domestic violence offense history, and batterer treatment variables to determine the influence reoffending arrest (Richards et al., 2014). It is noted that

overall, approximately half of DV offenders will re-offend, the arrest is quick for both domestic and non-domestic abuse (Cantos et al., 2014; Richards et al., 2014).

Police experienced multiple challenges in addressing DV repeat offending male population and Richards et al., (2014) reports these offenses are simultaneous with probation charges for the same offense. Also, this study looked into the male re-offenders committed DV crimes were either specialists, meaning committed DV crimes or generalists engaged in additional offending behavior two or more times within close proximity of the previous DV charges (Richards et al., 2014). History of stalking is included in DV reoffending behavior, as well as substance abuse. In fact, Richards et al., (2014) and Cantos et al., (2014) found that prior criminal records of DV charges and substance abuse are closely associated with DV repeat offending behavior. Protection orders were examined and found that women who obtain a protection order for approximately one year, are less likely to be offended multiple times, than those who do not obtain a protection order (Richards et al., 2014). Reviewing court cases from the Massachusetts District Court was this choice of method. Criminal history and DV recidivism cases were reviewed, the details of the cases were taken from various police reports (Richards et al., 2014). The majority of the findings were from white offending males being 83%, with records of 51.5% of men being re-arrested for the same offense two or more times (Richards et al., 2014). The strength of this study was the awareness of seeking funding for further research on innovative responses to DV and the weaknesses exemplified the need to further examine batterer recidivism over a longer period of time and determine if re-arrest are correlated with the time frame (Richards et al., 2014). This

study provided depth to the experience a facilitator may have working with repeat offending males and an understanding how this particular population functions, again with no signs of change.

Stanley, Fell, Miller, Thomson, and Watson's (2012) approach was by way of a social marketing campaign that targeted men's violence towards women. Social media can be challenging with DV due to the need to seclude oneself for safety reasons. However Stanley et al., (2012) chose a city in northern England, with 84 men drawn from community groups and participated in 15-focus groups (Stanley et al., 2012). Level of tolerance was decreased over time and the levels of DV have increased, with no signs of wanting to rehabilitate. Interestingly Stanley et al., (2012) reported men's perspective of their abusive behavior did not attribute it to being a problem; yet attributed blame to the victim. It is duly noted that breaking the cycle of abuse and repeat offending behavior is not to be taken lightly, and functioning on a level of understanding for all involved will align with best practice ethical stances. It is understood with the focus groups reflecting the general population of white British men, yet including five Black and Asian were attributed to the outcome of this study.

Some of the findings for barriers to change attribute to shame, stigma, vulnerability, and embarrassment (Stanley et al., 2012). During the mandate to participate in DV treatment programs can be a perpetuating cycle of refusing to take ownership of one's own action, or acknowledge the abusive behavior. Thus, refusing to take responsibility of the shame and guilt indicated major barriers for rehabilitating (Stanley et al., 2012). Knowing this approach of social marketing would get attention, it had to

provide a strong presence to make a difference in society to show the severity of DV, they also identified that the image of men of themselves as fathers was a key arena for intervention, and the effects this behavior has on the family system. Looking at the whole repeat offending male, and not solely at his behavior outcome is a good starting point of beginning the journey towards rehabilitation. Mennicke et al., (2015) and Stanley et al., (2012) both agree that assisting men to be vulnerable and look at the image they are portraying to their children, families, and the communities can assist towards change. This study provided the opportunity for specific research to understand the DV facilitators' intrinsic and extrinsic motivation of administering treatment programs to repeat offending males, with no sign of change.

Summary

Although there is literature specific to intrinsic and extrinsic motivation and DV facilitators for this topic area, there continues to be a gap in the literature of understanding the experiences of intrinsic and extrinsic motivation plays on the part of DV facilitators administering treatment programs to repeat offending males; with no evidence of change (Ben's 2012; Cinar et al., 2011; Truman & Morgan, 2014). This study was built upon self-determination theory and took into account other distinctions of motivation encountered by the population above.

What the researched literature failed to indicate is how this study of DV facilitators' intrinsic and extrinsic motivation is understood to continue to administer the same treatment program to reoffending men, without signs of rehabilitation. Additionally, I want to know how these facilitators make meaning out of their roles and value in the

workplace. Finally, to understanding the intrinsic and extrinsic motivation, I sought to understand if their feelings of value have any barrier on their overall lives and relationships. These gaps presented an opportunity to gain insight from DV facilitators. These research questions are combined into subquestions in Chapter 3. Chapter 3 will discuss the research method, and rationale. As well as, the methodology, data collection process and all the trustworthiness and ethical procedures required for this research design.

Chapter 3: Research Method

I used a qualitative hermeneutic phenomenological design in this study (Moustakas, 1994) to gain an understanding of the lived experiences regarding intrinsic and extrinsic motivation of facilitators administering DV treatment programs to males who habitually display DV behaviors. I also explored how DV facilitators process their feelings from this exposure, and how they perceive their intrinsic and extrinsic motivating experiences of providing the same rehabilitative service to mitigate abusive behaviors. Finally, I examined what, if any, coping strategies were used during this process. Within this chapter, I explain why I chose a qualitative methodology to explore participants' experiences and answer my research questions using a hermeneutical phenomenological design. I define my role as a researcher and identify potential conflicts and biases, as well as strategies to minimize and manage them. I explain the sampling strategy, data collection process, data analysis procedures, issues of trustworthiness, and ethical practices.

The qualitative approach provided the freedom to explore and interpret the lived experiences of DV facilitators (Mennicke et al., 2015). I used a hermeneutic phenomenological design to understand the essence of lived experiences regarding DV facilitators' motivation while administering the same treatment programs to males who were habitually arrested for the same offense (Giorgi, 2012). Obtaining an understanding of the lived experiences and maintaining close contact with stories provided can result in a deeper understanding of the layers of the human experience (Rudestam & Newton, 2015). The aim when collecting data on their lived experiences was to understand DV

facilitators' motivating factors in treating recidivist offenders (Becker et al., 2012). Moustakas (1994) indicated that conducting a phenomenological research study allows the participants to feel understood. Moustakas noted that to gain a "reflective structural analysis" (p. 13) that provides the core of the lived experience, a phenomenological design is preferred. Two strategies used to obtain data are open-ended questions and description (Moustakas, 1994). Moustakas stated the aim is gaining the meaning of the experience from the individuals who have experienced the phenomenon and producing a comprehensive description of it. This descriptive protocol is an open process that leads to refreshing perspectives from the chosen participants, which sheds a newness on the described experiences (Moustakas, 1994).

Research Design and Rationale

Research Question

Within this hermeneutic phenomenology study, I framed the main questions as a consolidation of the research questions, problem, and core concepts for this study. The research questions (RQs) were as follows:

RQ1: What is the essence or lived experience of DV facilitators' motivation while administering treatment programs to repeat offending males?

RQ2: How do DV facilitators perceive their role and motivation in the workplace?

As I analyzed the dominant concepts used in the research questions, I created open-ended interview questions that provided mutual dialectal communication (Appendix A). This process provided alignment between the primary questions, subquestions, interview questions, hermeneutic phenomenological design, and self-determination

theory. The purpose of the research questions was to help me gain an in-depth understanding of the DV facilitators' experiences, behaviors, and processes related to self-determination theory and intrinsic and extrinsic motivation.

Central Concepts

The central concepts I explored in this hermeneutic phenomenological study aligned with self-determination theory to describe the intrinsic and extrinsic motivation of DV facilitators when administering the same treatment program to repeat offenders without any signs of rehabilitation. The focal points of this study were the following concepts: (a) intrinsic and extrinsic motivation, (b) psychological responses to defeat, (c) social responses to defeat, and (d) coping mechanisms. The specifics and critical practicalities of intrinsic and extrinsic motivation are known as the core focus of performance (which is synonymous with behavior) (Cerasoli et al., 2014). Extrinsic motivation refers to the gains and losses or incentives, whereas intrinsic motivation refers to the mere enjoyment of the phenomenon (Cerasoli et al., 2014). When individuals are expected to administer a form of rehabilitation to a client with no signs of change, the lack of change may compound their intrinsic and extrinsically motivated reactions. Examples of with the influence on intrinsic and extrinsic motivation include the absence of achievement behavior, undermining effects, and the need to impose controlling external constraints (Cerasoli et al., 2014). The research questions and interview questions were designed to gain an understanding how these factors may affect the DV facilitators.

Paradigm and Tradition: Hermeneutic Phenomenological Methodology

The focal point for this hermeneutic phenomenological study aligned with my viewpoint that the meaning inclusive of cognition, affect, intentions, and anything that falls under the auspices of the participants' perspectives and their reality of understanding (Maxwell, 2013). The vast meaning of phenomenology is philosophically theoretical, adopted by research and translated into a methodology point of view, supporting the reality of the participants' experiences by human behavior determined by the phenomena (Sloan & Bowe, 2014). A qualitative hermeneutic phenomenological design provides a framework for understanding another person's personal spaces, identities, cultures, views, and the problems and solutions that may exist. This method allowed for communicating with the participants to reveal their feelings, thoughts, and perspectives. Interviewing someone is imperative to understand life through his or her eyes. In addition to describing the participants' feelings, thoughts, and perspectives, it was important to make sense of what they experienced, as well as illuminate the specifics of particular events that may have gone unnoticed (Maxwell, 2013).

In this hermeneutic phenomenological study, I focused on the perceptions of the participants regarding the things within their world (Sloan & Bowe, 2014). Phenomenology is the study of a person's experiences related to the phenomenon, in which the researcher collects, analyzes, and interprets the data (Sloan & Bowe, 2014). Hermeneutics is the interpretation of text or language used to explain the phenomenon (Sloan & Bowe, 2014).

Phenomenology is language revealed by an individual in a cultural or historical context that is understood by the participant and researcher through the interview process (Sloan & Bowe, 2014). Sloan and Bowe (2014) suggested that "phenomenology informs, reforms, transforms, performs, and pre-forms the relationship between being and practice" (p. 7). The evolution of hermeneutic phenomenology from philosophy to methodology enabled researchers to interpret the participants' existence within their world, which was very important for my study. Within this evolution of hermeneutic phenomenology from philosophy to methodology, bracketing of influences around the researched phenomenon enabled researchers to access the core of participants' lived experiences (Sloan & Bowe, 2014). The focus of descriptive phenomenology is the noema experience or "the what" and the noesis or "the how it is experienced"; once these thing have been analyzed, the work is complete (Sloan & Bowe, 2014).

In this study, following the hermeneutic phenomenological design allowed me to interpret the meanings in relation to the phenomenon (Sloan & Bowe, 2014). The focal point was understanding the meaning of the participants' experiences by analyzing and interpreting the data. My approach was compatible with Langdridge's (2007) and Sloan and Bowe's (2014) understanding of the specific aspect of the participants' human experience of the world.

Rationale for the Qualitative Methodology

Qualitative research is a process that involves inductive data analysis to understand the in-depth meaning of the problem from the perspective of the participants, through identification of patterns or themes (Lewis, 2015). This approach includes open-

ended interview questions to gather information, which is grouped into categories and eventually themes (Lewis, 2015). When conducting a qualitative study, it is necessary to "assess the relationships to the purposes and circumstances of the research, rather than being a context-independent property of methods or conclusions" (Maxwell, 2013, p. 121). There are various approaches to reaching this goal within the realm of qualitative research such as grounded, narrative, case study, ethnography, and phenomenology. All qualitative approaches share a common process of collecting data, analyzing them inductively to gain knowledge of the meaning of the problem, asking open-ended questions, evaluating data, searching for similarities within the data set, identifying differences between categories, and summarizing the results (Akerlind, 2012; Lewis, 2015). Additionally, qualitative provides freedom for the researcher to glean from the chosen theory and expound on the findings of succeeding data (Lewis, 2015).

Qualitative research is flexible rather than fixed, and involves inductive analysis rather than a rigid regimen (Bohren et al., 2014). Although there were some studies that addressed facilitators' responsibilities to a particular phenomenon (Jones et al., 2010), I found no studies that focused on DV facilitators' experiences of intrinsic and extrinsic motivation while administrating the same treatment program to repeat offending males without any signs of rehabilitation. The grounded theory focus is on rigorous research actions, which lead to the emergence of conceptual categories (Cho & Lee, 2014). I sought to understand the processes underlying how DV facilitators intrinsically and extrinsically respond and cope with administering a one-size-fits-all treatment program to repeat offending males who show no signs of change.

Narrative researchers have placed their focus on the DVs' or the intimate partner violence (IPV) survivors' perspective of the changes experienced through treatment programs (McGinn, Taylor, McColgan, & Lagdon, 2016). Narrative studies require the researcher to say very little and be used as a catalyst for listening to the experiences. With the sensitivity of DV, it is not feasible to only listen, but be an active part of the interviewing process. An ethnography and case study was considered because these approaches offered an in-depth look into the cultural and history of multiple components for this study. However, these designs do not provide the freedom to target the specifics and objective of this study. This research study sought to provide a descriptive understanding of the processes that occur in the lives of DV facilitators' motivation intrinsically and extrinsically when administering the same treatment program to repeat offending males.

Viewing the literature from a quantitative approach provided a valued and examined, yet scarcely focused viewpoint (Leppakoski, Flinck, & Paavilainen, 2014). Although I attempted to use a quantitative approach to this study, it did not provide the opportunity to deliver an in-depth explanation from the participants' perspective that surpassed merely measuring specific variables (Leppakoski et al., 2014). My choice of method being hermeneutic phenomenology gained an understanding through the lived experiences and to gain great insight through the participants' direct involvement and daily exposure to the phenomenon (Akerlind, 2012). Akerlind (2012) also suggests phenomenography research methods not only describe variation in human meaning, understanding, and conception, but awareness of the actual experience.

This study provided a direct insight into the perspective specifically to DV facilitators' intrinsic and extrinsic motivated experiences as helping professionals, that are expected to provide a rehabilitative program that is presented as a general solution to multifaceted DV behaviors amongst repeat offending males; without any evidence of change. More prominently, this study provided a voice for the helping professionals who are facilitating DV treatment programs and acknowledge the DV facilitators' experiences. Using the self-determination theory (SDT) offered the research community insight into intrinsic and extrinsic motivation of behavior, which laid out a platform for future studies, resulting from my study's conclusion. As a result, specific change to policy and delivery of service developed, whereby methodical perceptions could be enlightened and applied to diverse DV treatment programs that are developed and based on theoretical groundwork.

Role of the Researcher

My primary focus in the researcher's role was to assure that all aspects of this research study, analysis, its project, and the complete implementation, was focused in a manner that highly adhered to the ethical guidelines and close attention to the treatment of human subject protection for all the volunteered participants for my study (Maxwell, 2013). As a Licensed Professional Counselor (LPC), and a Human Service Certified Board Practitioner (HSBCP), as well as, being an active member of the American Counseling Association governance, and National Organization for Human Services (NOHS), I am bound to uphold the ethical standards set by both organizations. It is of the utmost importance to plan, design, conduct, and report research that is consistent with

specific ethical principles, federal and state laws, host institutional regulations, and scientific standards (ACA, 2014; NOHS, 2015), as well as, consideration to cross-cultural biases and is reported in a professional manner that addresses any limitations (NOHS, 2015). To conduct this type of research, it was vitally imperative as a researcher to function with integrity and with the intents of service, which encapsulates the helping professional's commitment to humanity. With this type of commitment I stand by, it is not necessary to seek further training, as I currently have the required skills critical for this in-depth research study. The upkeep of records handling practices were implemented to protect the confidentiality and privacy of the participants, solely based on standards set by Walden University's Institutional Review Board, ACA governance (2014), and NOHS (2015). In addition to the importance of protecting the participants as a researcher, an informed consent was administered prior to the collection of any data. It was also my responsibility as a researcher to follow the chosen research proposed, with being fully competent within my belief system, which aligns with the superiority and thoroughness qualitative methodology provides.

Philosophically, I orient with hermeneutics with phenomenological influences. It is my belief that everyone has a voice that paves the way to the explanation of his or her personal experiences, towards some exposure to a particular phenomenon that becomes evident through the meaning obtained from this exposure. From my perspective as a researcher, I sought to understand the very essence of the DV facilitators' lived experiences, leaving out any personal biases that could taint the outcome and process, and with the gathered data provide meaning to their spoken words. As a hermeneutic

phenomenology researcher, this design is based on human meaning, understanding, experiences, and conceptions, however the reality also lies within structural relationships between different ways of experiencing the phenomenon being experienced (Ackerlind, 2012). In other words, there are not two worlds to conjoin, but the world is experienced by the participants and their experiences constitutes a relation between them (Ackerlind, 2012). During this study, I was immersed in the entire process of interviewer and interpreter (Ackerlind, 2012).

It was also my duty as a researcher, to acknowledge and manage any form of history, and experiences that may present biases within my study (Maxwell, 2013). I am fully aware that my experience of operating in a leadership position, I had the training and qualities of conducting interviews replete with open-ended questions. This skill helped when conducting the actual interviews. The importance of this training provided the understanding of asking questions that stayed within the realms of ethical and credible outcomes. I learned and understood through my training as a therapist the importance of being present, and utilizing listening skills to further probe for additional relevant information, which provided a rich study. As a researcher, I was aware of my responsibilities at all times and maintained an ethical stance.

Finally, I feel it was my responsibility to include the standards set by Walden University's Institutional Review Board and the aforementioned ethical guidelines set by ACA (2014), and NOHS (2015). I was responsible to create an atmosphere with my participants, which they not only felt protected, but they were actually protected from any form of harm.

Mitigating Power Differentials

Some concerns this study may face was how the participants will respond to the reality of implementing a treatment program habitually; without signs of rehabilitation, consequently, these differentials was taken into consideration and was be managed. It is the possibility the participants may have experienced feelings of being undervalued, the focal point of rehabilitation may become skewed, best ethical practices from a helping professional may not occur, and they may become desensitized to the severity of DV sanctions (Riel et al., 2014). Therefore, as a researcher, it was vitally important to be cognizant of the possibility of any negative exposures of this sort. To further assure these feelings were not taken lightly, and continue to manage any power differentials, I demonstrated unconditional positive regard during the interviews; quickly established a rapport, exemplified respect, and honor, all the while protecting the confidentiality and privacy of the participants.

Study Risks

I did not experience any study potential risks, which may be experienced past the emotional aspects of discussing their experiences. As a researcher, I prepared some resources for the participants', which are located within the Dekalb County, Georgia area. I did not collect any financial data, nor obtained data from medical records. No compensation of any kind such as paid participation and stipends were offered for this study. I hoped the participants gleaned from participating in this study the opportunity to find their voice and tell their stories unequivocally.

Potential Conflicts and Biases

Being aware that this study required face-to-face interviews with individuals with a real-life phenomenon required that I remain aware of how my biases had to be managed for the protection of the human participants. I utilized bracketing, which focused on maintaining a stance as a researcher, to keep assumptions, and preconceived notions at a minimal to prevent the evolvement of biases (Hart-Johnson, 2014). Functioning as a qualitative researcher, I was consistent with functioning as the primary instrument used for discovery and incorporate reflexivity for the management of my biases (Hart-Johnson, 2014). Maintaining equality throughout my semi-structured interviewing process comprised of questions and subquestions that used the same content (Hart-Johnson, 2014). I did not assume the outcome of the questions asked to the participants (Robinson, 2014).

Ethical Considerations

Moving forward with the full understanding of the importance of maintaining a very high level ethically, was the stance this researcher abided by. As a guidance, following the ACA (2014), and NOHS (2015) code of ethics was adhered. Additionally, following the codes of ethics, and the need to complete this study using human subjects, I have completed the National Institution of Health (NIH) (2011) Protecting Human Research Participants training (Appendix E, Certificate Number 1433020). The specifics of this training remained focused on teaching the importance of justice, beneficence, honor, and respect for humankind. Close attention was made in safeguarding the human subjects, through using precautions set in place by the IRB, ACA, and NOHS code of

ethics, the distribution of this research was addressed by making sure the participants felt a sense of strength to expound freely on their story, and providing throughout this entire research study confidentiality. As a researcher, I followed all the specifics set Walden University's IRB application, which addressed human subject research with the importance of sustaining a pivotal level of privacy, respect, and confidentiality.

Potential risks of any ethical violations included, data being misinterpreted, inappropriately interacting with research participants, unable to maintain an unbiased stance, the breach of privacy, and the lack of academic excellence. The justification of these risks was implemented by following the practices mentioned in the previous information, such as managing for potential risks and privacy. To further protect the identity of the participants, the original names of the human subjects were not used. Finally, the use of deceit in obtaining my participants through advertisement and making false promises did not occur. I sought wise counsel from my doctoral chairperson, to reduce and possibly eliminate any risks of harm and misinterpreting of data.

Methodology

Participants and Sample

The sample for this study was DV facilitators who administer treatment programs to repeat offending males. The geographic location was in the Decatur, Georgia area. The purpose of this selection is outlined in Chapter 2, where as a result of the men that choose to re-offend within the realms of domestic violence, the facilitators are expected to administer the same treatment program; without any signs of rehabilitation. To gain an

understanding of this experience from those that function in this capacity was a natural and rational fit.

For this study's plan, the criteria for the chosen sample, informed consent, and all the documentation used for initial recruiting, managing all documents and analysis was approved by Walden University's IRB. A copy of approval is included in Appendix F.

Description of Research Participants and Selection Criteria

Approximately 6-10 DV facilitators' was the projected number expected to use for this study from one site because this site is used often and conjoined with the DeKalb County courts to facilitate those DV court-ordered sanctions. Cattaneo and Goodman (2015) suggested choosing an organization that seeks to empower change and is a part of the anti-domestic violence movement is ideal for recruiting those that are consistently exposed to the same phenomenon. This is because the signing of a contract between this organization in the NE county in Georgia and that county court was conducted for a period. As an addition, or alternative, this study followed Cattaneo and Goodman's (2015) strategy, which suggested reviewing some of the records kept by the helping professionals. They referred to this approach as a bridge concept.

Another important benefit of choosing this particular organization was to assure the targeted purpose of this study was adhered to and ensured the cusp was focused and clearly defined from the sample chosen. The organization is widely used in Georgia and provides a wealth of knowledge towards this exposure of repeat offending males.

In order to keep this study focused on my research questions, the inclusive criteria was stated in the initial verbal communication, recruiting flyer, to avoid any form of

judgment due to a person's race, color, and creed. (See Appendix F for a detailed view of the informed consent.)

Sample Size

The sample size for this study was seven participants. Within any qualitative research study, the sample size is generally small. However, in some instances for example, within a meta-analysis study the sample could be rather large to achieve the validity or to generalize towards the outcome or results. Using a plethora of organizations within Georgia domestic violence sector could render emergent circumstances, whereby the assumptions of collected data may result in a change as it is being analyzed, and there is a possibility of increasing the sample size. Phenomenology theory is interested in the recovering of an individual's living experience (Patton, 2015). The dependence of the sample size was the choice of the researcher, which provided seven participants and I continued this cycle of data collection until saturation was maximized (Hart-Johnson, 2014).

Byran, Cardon, Poddar, and Fontenot (2013) suggested a minimum sample size is expected within qualitative studies that build rationale, criteria presented alerts the inadequacies within the sampling approach and size, and sampling to the point of redundancy is ideal. Saturation was reached when no new data emerged during the interviews and when the identified themes were redundant.

Justification of Sampling Strategy

For this study, I utilized an inter-mix of sampling strategies such as face-to-face interviewing with DV facilitators, as well as extracting information from their testimonial

notes, and member checking for triangulation. Rudestam et al., (2015) suggested to gain an understanding of the data, may be conducted through multiple means. Rudestam et al., (2015) stated the triangulation process occurs when the researcher obtained data from various bases. The sample was obtained from the same organization, however, multiple ways of gaining additional information, (interviewing, member checking and testimonial notes) as a way of retrieving the depth of the experience. I used a purposeful approach when obtaining my sample, as well as, some of the specific testimonial notes from the DV facilitators, and member checking. I used multiple means of recruitment such as flyers, and recommendations from the Executive Director of the domestic violence organization. The multiple means of recruitment helped to reduce selection bias and allowed the careful attention to refraining from causing any ethical harm.

Recruitment Process

Once I received IRB endorsement, I immediately contacted the executive director of the domestic violence organization and informed him of my study and the intentionality of conducting this with his DV facilitators in a nonobtrusive manner. I scheduled a face-to-face interview with him to present required documents approved by the IRB, and to obtain his signature. Once this occurred, I placed the created flyers on the organization's public bulletin board located within the office. After reading some of the requirements of obtaining data from participants from the IRB Walden University website, suggested flyers provide the freedom for participants to choose to be a part of the research study. I had the appropriate letters of cooperation when meeting with the director, as well as, the participants. In addition, within the flyers placed on the public

bulletin board within the organization, I provided instructions for contacting me via telephone, or password protected email, to protect the anonymity of the participants. Any messages left on voicemail, was password protected also.

The description of the actual way sampling was conducted is expounded upon in chapter 4. When the DV facilitators contacted me to be a participant in this study, I scheduled the day and time that was most convenient for them. The participants had an opportunity to choose to be a part of a telephone interview, or a face-to-face interview. Being mindful of not causing any harm with the participants, the telephone interviews were offered. The DV facilitators that chose to be a part of a face-to-face interview were conducted in a private office in Georgia. I conducted each interview averaging 30 to 60 minute intervals.

I recruited my participants as they called or through the protected email advertised on the flyer to continue with the consistency and preserving their anonymity. It was vital to make sure the participants' confidentiality was preserved through careful attention to the details of every aspect of this process of obtaining participants, such as using a private messaging e-mail feature and creating a Google telephone number specific to my study for the screening process. When the participants called the specific Google number, it rang my password-protected cell phone with a special ring. When the call was answered, the Google automated voice mail asked if I wanted to accept the call or send it to a prepared voicemail. The importance of these features was to alert me of what call was coming in and staying in line with protecting the participants; I had the opportunity to accept the call in privacy. The formatting of my flyer had all the necessary information

and instruction to assure the importance of being a willing participant without coercing and the importance of this study. The completed and approved flyer is included in Appendix C, which was inclusive of an e-mail, Google toll-free number for screening and a toll-free number using www.FreeConferencecall.com.

Instrumentation

I was the primary instrument for this hermeneutic qualitative research study (Bryan et al., 2013). As such, I designed a semi-structured interview guide for my study. Throughout this section, I discussed how I tested, designed, analyzed the data, gathered, and identified themes during the data collection and interview process.

The semi-structured interviewing process was designed using predetermined questions that were coordinated with the chosen research questions (Appendix A). I constructed these research questions in a manner that invoked insight from the participants' experience. Within this research study, my predetermined questions were arranged based upon the participants' exposure to the phenomenon, as well as, the lived experience. Bryan et al., (2013) discussed the importance of the interviewer to shift sides of the spectrum from being the focus of the interviewing process to being the recipient of information. Making sure all biases were obsolete during the interviewing process is vital and maintained. During the interviewing process, the participants elaborated on their experiences and serve in the role as the proficient professional.

The prepared interview questions were taken from multiple ways to assure the freedom of the participants to express their experience. Bryan et al., (2013) reported the importance of conducting an in-depth interview where the human subjects are free to

express their lived experiences. I allowed this autonomy during the pre-screened interviews. Bryan et al., (2013) suggested in aligning my research questions with information that is thoughtful and where it allows the participant to elaborate freely on their human experiences. Bevan (2012) discussed as a novice researcher, it is important to be mindful of some of the language within phenomenological being complex, along with the concepts between descriptive and interpretative orientations. I made sure I was familiar with internalization of the concepts with immersion in and applying the phenomenology method. I included probing during the interviewing, to gain additional information, which was inclusive of any essentials of change. The phenomenology design maintains a theory and practice link of a natural attitude, or involvement in the world, and lifeworld, or consciousness of the world (Bevan, 2012). As a researcher, maintaining a natural attitude will be effortless of unreflectively being engaged in a world that is known, however the challenge of the experience of the lifeworld is what is under investigation in phenomenology (Bevan, 2012). In other words, my attitude of the world and how I have come to know it is effortless, but when interviewing someone else's perspective it is imperative to step back and allow the subjects to function as the expert in their experience. For example, Bevan (2012) found that a natural attitude is different for everyone; therefore, a person may view the same phenomenon in different ways. These multiple ways provided the phenomenon with an identity, thus creating themes necessary when coding using open and axial coding. Although both the interviewer and interviewee are on the same level, the process allows one to be the recipient. To ensure I remained in the position of recipient during the interview, I was aware of any biases that may hinder

this process of understanding, to uphold an ethical stance and abiding by the standards set by the IRB and Walden University. The influential phenomenological researcher focuses on the generality of questioning, although being general initially; I remained in the vocabulary and language of the interviewee (Bevan, 2012).

I created my interview process with the focus of eliminating any sense of power struggles, blatant and inadvertently. Please see Appendix A for details. Bevan (2012) further discussed when a researcher is faced with any form of power struggles, to reassure the interviewee of the importance of their input about their experience and being protected as a participant within a research study. I was cognizant of treating the participants with the utmost respect and providing my delivery of language to be understood for all ages. To ensure the language was understood, and all information presented to the subjects was clear, I used the Flesh Reading Ease Test (Hart-Johnson, 2014). This test is free and compatible with Microsoft word 2007, Outlook 2007, and Office 2007.

During the interview phase of this study, it consisted of the interview with the executive director of the DV organization, interviews with DV facilitators, and probing (provided in Appendix A). Careful attention was added to check for validity in the interview questions. One of the guidelines DeFelice, and Janesick (2015) set for phenomenological smaller scale studies is, using the approach of the experience of the describer. In other words, when obtaining the information from the participants, sometimes the interviewer can become immersed in the experience and take ownership of it as a form of relating. In this study, the process was avoided by designing an outline

identifying the primary and secondary level of questioning to maintain order, identified concepts, and consistency.

Next, I authenticated each concept was applicable to the participants, and all questions were consistently following the phenomenological development. In other words, Bevan (2012) suggested all questions, whether presented primary or subquestions they all must be consistent with all participating individuals. In conjunction with following the guidelines of Flesch Reading Ease (aforementioned), the language used was clear and concise. All responses presented by the participants were clarified by asking through paraphrasing their information, and then asking for authentication. Lastly, during this process, I continued to respectfully probe to gather levels of depth towards their experiences. With all the aforementioned steps assisted me in staying in line with presenting valid and credible information.

Data Collection Techniques

The data collection was conducted mainly through semi-structured interviews and some of the DV facilitators' member checking, and testimonial notes. This research occurred once I received approval from Walden University's IRB, (Approval No. 08-29-16-0427800). There were two ways I collected data, through telephone interviews and face-to-face. I met and interviewed the participants either in the designated private office in Georgia or on a private conference call. As the researcher of this study, I was the only individual handling every portion of this data. I conducted seven interviews. In maintaining the consistency of being present during each interview, I did not exceed approximately 3-4 interviews per day. The interviewing process lasted approximately one

week. The semi-structured questions were designed and used during all the interviews. This structure provided order and clarity for all the participants equally. Integrity was crucial during this process and following the consistency of the interview process presented uniformity and when comparing the data. Being a licensed therapist, I understood the importance of being present psychologically and physically, actively listening as Bevan (2014) suggested without wanting to develop interrogative presuppositions. Maintaining this stance prevented an overextended interviewing process, due to reflecting, or paraphrasing the information presented by the participants.

When this entire data collection process began, I anticipated the human subjects would call the telephone number on the flyer, I explained the research study in complete detail, and then followed the process of screening participants outlined on the informed consent. Once the participants' met the agreement, by proof through the informed consent, I scheduled a face-to-face or telephone interview right away. The interview was scheduled very close to the ending of the screening to keep the high momentum of agreement to participate in this research study. In addition to the face-to-face interviews, I reviewed some testimonial notes for the consistency of triangulation against information found within research (Bevan, 2014).

The informed consent was extremely important prior to conducting the interviews. When I met with the participants for the face-to-face interviews, I discussed the entire informed consent with them and then required their signatures prior to the actual interviews via email with "I consent." I followed all the requirements set by the IRB for conducting interviews.

Once all the interviews were concluded, I debriefed with each participant on what will occur moving forward to the duration of the research study (which is inclusive of sharing the transcribed data). Follow-up questions were answered.

Once each interview was completed, I transcribed the data within a reasonable period. It was helpful to transcribe within a reasonable time to prevent any loss of important information relevant to this hermeneutic phenomenology study. Bevan (2014) suggested it being wise to maintain a self-evaluation reflection after each conducted interview to be aware of personal feelings, thoughts, and specific areas pertinent to the study. During this process, I documented my thoughts on analysis on my password protected computer and saved them on a flash drive which remained locked in a fireproof file cabinet, where I utilized the only key, as well as a hard-bound journal I carried around with me to record field notes and thoughts. With the amount of information collected, it was imperative to use identifiers for the interviewers. The identifier's was unique to each participant by using "tech," and then followed by a sequential number for a simple manner of recognizing the content within each file such as ideas, theory-related notes, and concepts (Hart-Johnson, 2014).

Data Management and Analysis Plan

The data analysis was presented in a sequential manner to match the sequential number of the files above. Once the interviews were complete, managing of data, analyzing the data, coding through open and axial, and then interpreting this phenomenology study occurred.

Interview folders were marked with a specific identifier number that indicated the date the interview occurred, type of interview, and finally a specific number for each participant (i.e. Tech06092016-01P, the P stands for phone interview, June 9, 2016, the interview took place with the interviewer number is 01). Although there were confidential ways of protecting the participants, the content of the interviews was consistent when analyzing the data. All informed consent forms were kept on each participants' file that was locked in a safe fireproof filing cabinet.

Data Management

Careful attention to the handling of all the data assisted with staying in lines of operating with integrity and protecting the confidentiality of all the participants. All the data above, testimonial notes, tape recordings, and any additional identifying information was secured within a fireproof locked filing cabinet; acquired specifically for this dissertation process. I obtained the only key to this filing cabinet. Electronic data was kept in a labeled folder, and stored within filing folders on a password computer. As mentioned above, all documents were password protected. To maintain the clear identification of files, unique names were provided for each. Daily storage of each folder was placed within the secure locked fireproof filing cabinet, as well as, the flash drive, or USB drive with the additional pertinent information. The allotted time for the storage of this data will be five years from completion. All audio tapes were erased after each interview and transcription.

Data Analysis and Coding

Hermeneutic phenomenology theory is a structured approach; questions are based on themes of experience contextualization, gaining the phenomenon and clarification of the results, descriptive, and a novel use of an imaginative variation of exploring the experiences (Bevan, 2014). Analyzing the data followed the transcription of interviews. However, apprehending of the phenomenon occurred during the actual interview. The language spoken during the interviews were transcribed to maintain the highest point of data retrieval.

All collected data was compared to both the primary and secondary questions. The comparison ensured all aspects of the questions were addressed. The interview questions were a derivative of the research questions. The information gathered from the participants was identified as raw data used for open and axial coding. Bevan (2014) and Hart-Johnson (2014) suggested using two sets of coding was ideal for not only grounded theory approaches but also for a phenomenological approach and this process will create a high standard of summarized coding.

When data was identified through the coding system, it aligned with my research questions:

RQ01: What is the essence, or lived experience of DV facilitators' motivation while administering treatment programs to repeat offending males?

RQ02: How do DV facilitators perceive their role and motivation in the workplace?

All collected data was coded according to the research questions and compared with member checking, testimonial notes, and memos, to continue with the consistency of triangulation. I am aware of emerging themes occurred during the coding process and provided an understanding of what type of data was needed next. The patterns developed into major concepts and will be further elaborated upon in Chapter 4.

Data Analysis and Interpretation

Interpreting data is a process that is inclusive of data collection, and change. Inductive and emergent themes flood the phenomenology process, and categories from the data may identify gaps (Dworkin, 2012). It is also the high quality of data, the scope of data, nature of the topic, the amount of useful information, shadowed data, and chosen method that will further assists with analyzing and interpreting (Dworkin, 2012). The process of interpreting occurred throughout the duration of coding and sampling.

Coding qualitative studies identified the relationships to one another. Dworkin (2012) discussed this portion of a qualitative research study is a continual process of analyzing data. Also, the sorting process provided the understanding of the data that was under review. As the emerging themes arose, I analyzed them for a common connection and sought to understand how each one was related. Once this was completed, I moved into interpretation.

Also, the importance of triangulation with other data such as testimonial notes was adhered. During this process, there were no discrepancies that required addressing for the prevention of flaws. As the steps above were completed, the results are elaborated on in Chapter 4.

Verification of Trustworthiness and Authenticity

The importance of and maintained goal for this study was inclusive of the community being made aware of the problem in a clear and valid manner for the repetition of future researchers to mimic. Providing credibility in a manner of produced clarity was the key to the achievement of this study. Bevan (2014) discussed how vital it was as the researcher to have a biased free research study with a clear indication of producing a valid, credible, and reliable study.

Establishing Credibility and Reliability

Knowing one of the main goals of any research study was taking the careful steps to have a credible study, approaching the process from a standpoint that looked at the saturation, triangulation, flexibility, and assuring the participants were comfortable will lead to reliability (Bevan, 2014). Triangulation conducted through addressing multiple ways of collecting data (i.e. recruiting) which led to various aspects of analyzing, member checking, confirmation of the theory, and validating the testimonial notes. During the interviewing process, I probed for additional meaning or member checking. I do not believe it was a need to follow-up with the participants. However, clarification was provided during the debriefing process following the interviews.

Validity Threats

Keeping threats of validity to a minimum, the researcher will guard against biases, reactivity, and faulty reasoning (Bevan, 2014; Hart-Johnson, 2014). Having an understanding of what biases and assumptions could occur reduced researcher's biases. A great way I felt to be cognizant of my feelings as a researcher during this study was to

document my inner thoughts and feelings. The possibility of harnessing every thought and feeling into captivity may be challenging, thus the reason for documenting to be in a constant place of awareness and to prevent producing defective information (Hart-Johnson, 2014). It was my goal to be aware and managed my actions throughout the entire research process.

Additional Ethical Procedures

Data Confidentiality

Maintaining confidentiality is ethical and necessary. As a licensed therapist, protecting the participants' identity is crucial, and careful attention to this occurred. During this research study, each file was assigned a number that acted as identifiers for each participant on all materials used for the interviewing process, data transcriptions, and store all material in a such a way that was not be linked to any one specific person. The volunteered participants' information was kept in a fireproof locked filing cabinet for the possibility of follow-ups during the transcription process. However, I discarded this once this process was complete.

Supporting the participants after the interviews was inclusive of providing available community resources, free of charge, to address any possible levels of stress the interviews may trigger. The Resource List is available in Appendix D. All participants were assured that their specific identifying information was kept in the strictest of confidence for this study. All materials was locked and secured in the event of the necessity of an audit.

Informed Consent

Another heighten way of ethically protecting the participants was through an informed consent (ACA, 2014; NOHS, 2015). When meeting with the participants, an informed consent document was provided via email that explained my entire research study and their protection by choosing to be a part of this process. The informed consent was imperative to advise the participants' so they were aware of what they agree to. The information was clear and concise as outlined, as well as the requirement in the Walden University IRB Consent Form. Also indicated on this form were any possible benefits or risks. For the organization of this study, the informed consent occurred during the telephone contact. Also, indicated within this study, there were not be any offerings of any monetary gifts, and this information was provided within the informed consent.

Summary of Research Design

Within Chapter 3, I provided an understanding of the choosing of a qualitative methodology, using a hermeneutic phenomenological approach. Exemplifying a clear qualitative paradigm was hoped to be understood through this study's research questions. The provision of the role as the researcher was crucial during this process and the rationale was aforementioned, outlining the ways to minimize biases, management of power, and any arising conflicts.

Previously, it was discussed that the collection of data, instrumentation, specifics of data management and interpretation, processes, and techniques. The researcher discussed the strategies to maintain trustworthiness for this study. Lastly, high ethical consideration is provided and being competent as a researcher. Chapter 4 will provide the

actual setting for this research study, demographics of the participants, data collection processes, the controls put in place to guarantee an extension of trustworthiness carried out through all the process, as well as within the presented results.

Chapter 4: Results

The purpose of this study was exploring the experiences of DV facilitators and their self-determination, motivation, and treatment planning in working with repeat offending males. A hermeneutic phenomenological design was used for the study. This chapter provides a description of the research setting, ethical considerations, and data analysis including first and second cycle coding. I conclude the chapter with a summary of the results and answers to each research question and subquestion.

The Research Setting

I conducted this study in Decatur, Georgia. Data collection occurred between August and September of 2016. Four of the seven interviews were conducted in person at the specified facility identified during the planning phase of the study. Each interview was held in a private office or by using a secured telephone conference line. All participants determined their interview preference based on personal choice and convenience. I maintained a participant's communication log, recording only their coded name and pseudonym to maintain confidentiality. After approval from Walden University's Institutional Review Board (IRB), I contacted the executive director in charge of the facility where my study took place and participants were recruited. In accordance with my recruitment strategy, the executive director scheduled his interview and placed flyers on the organization's bulletin board as a means of recruiting other participants.

Ethical Considerations

All ethical standards and protocol discussed in Chapters 2 and 3 were adhered to. The Walden University IRB approved this study including all corresponding documents (IRB Approval No. 08-29-16-0427800) prior to data collection. Nicholls et al. (2015) suggested for the proper assessment of ethical practice in research, it is important for all research documentation to be thoroughly examined.

At the beginning of each interview, I read the informed consent to each participant to ensure eligibility was met for participation in the study. Prior to the scheduled interviews, each participant was informed of the potential psychological risks, duration, expectations, benefits, and follow-up activities that might be required. Participants were given a mental health and community resource listing that provided services at no or low cost. Copies of this community resource listing were left at the organization for each participant. All documentation pertaining to each interviewee was assigned unique numeric identifiers.

Participants' Demographics

This section provides a summary of the research respondents who met the study's inclusion criteria and agreed to the informed consent. I omitted participants' identifying information to ensure confidentiality. Following this protocol of protecting DV facilitators' identities, I was able to use verbatim quotes. Pseudonyms allowed me to honor the confidentiality of each participant by giving them a specific number and name, which will be referenced throughout this study. The participant profiles varied due to the research questions not designed to capture the participants' demographic information but

to answer the specific research questions. Table 1 provides an overview of demographic information and is followed by a short narrative of each participant's profile. In the organization chosen for this research study, there were no female DV facilitators employed; all participants were male.

Table 1

Summary of Participant Demographics

Pseudonym	Years of Experience	Working status	Level of Education (self-reported)
Adam	22	Executive Director/ Facilitator	College Graduate
John	10	Assistant Director/ Facilitator	College Graduate
Samuel	12	Director of Training/ Facilitator	College Graduate
Joseph	9	Orientation/ Facilitator	College Graduate
Daniel	30	Director of Men Education Facilitator	College Graduate
Joshua	*	Facilitator	College Graduate
Elijah	3	Facilitator	College Graduate

Note. *Participant Joshua did not disclose years of experience.

Participant 1

Adam serves as the executive director and facilitator. He facilitates treatment programs once a week for approximately two hours per week in the 24-week class. Occasionally he facilitates a court-mandated 3 ½ hour class at the court of law in Georgia. He has been a facilitator for approximately 22 years. Adam is a college graduate.

Participant 2

John serves as the assistant director and facilitator. He facilitates the DV treatment programs once a week for approximately two hours and has served as a facilitator for approximately 10 years. John is a college graduate.

Participant 3

Samuel serves as the director of training and as a facilitator. He facilitates once a week for two hours and has facilitated for 12 years. Samuel is a college graduate.

Participant 4

Joseph has served as a facilitator in the organization for 9 years. Joseph is a college graduate.

Participant 5

Daniel serves as the director of men education and as a facilitator with this organization. He has facilitated since 1986. Daniel is a college graduate.

Participant 6

Joshua serves as a facilitator. He did not specify the exact length of employment but noted that it had been for a significant amount of time. Joshua serves as a facilitator Monday through Friday for 1 ½ hours per class. Joshua is a college graduate.

Participant 7

Elijah has served as a facilitator with this organization for 3 years. He facilitates every Monday night. Elijah is a college graduate.

Recruitment

As described in Chapter 3, I used a purposeful sampling strategy for the recruitment process. My goal was to recruit a homogenous sample to reach data saturation (Dworkin, 2012). The purpose of this strategy was identifying participants who had a common understanding of the research problem and were experts on the subject matter. I originally sought to recruit at least six to 10 individuals, assuming that I would lose two individuals through attrition (Teare et al., 2014). Ultimately, the goal of recruiting seven participants was achieved.

Data Collection Process

This study's data collection process was guided by the inductive nature of qualitative inquiry. After I added the IRB number to the final draft of the recruitment flyer, and with the permission of the facility where my study was conducted, the director placed the flyer on the bulletin board of the designated domestic violence organization. On August 30, 2016, I began data collection. I recruited seven self-identified domestic violence facilitators actively facilitating treatment programs to repeat offending males

from the Decatur, Georgia area. Participants responded by calling or emailing me. My cell phone voice recording was modified specifically for this study, directing participants to leave a contact telephone number if I was not available when they called. All participants received an invitation to participate in this study in an informed consent document via email (see Appendix A). The email also indicated instructions for scheduling a day, date, convenient time, and location (face to face or private conference call). During the initial telephone contact, the date, time, and location were chosen. All participants responded with "I consent" via email indicating they were willing to be a part of this study. A confirmation email including the date, time, choice of interview, location, and private conference call information (if needed) was sent to each participant.

Dworkin (2012) stated that saturation is the point at which data collection is no longer offering new or necessary data. I concluded saturation was reached when no new data emerged from the seven interviews. Fusch and Ness (2015) indicated a small study will reach saturation more rapidly than a large study when the ability to obtain additional information is no longer feasible. Following a brief review of the informed consent material and each participant agreeing to record the interviews, I conducted the interviews. The first interview had the longest duration of one and a half hours. The other interviews averaged 18 to 30 minutes. I guided the interviews using probe questions to assist the participants' with remaining on topic. All notes and referenced documents were stored in a secure location as identified in my IRB form. I did not encounter any variations or unusual circumstances during the interviewing process.

Data Management and Tracking

Data management techniques involved organizing all data for this study using consistent records management practices. I consistently maintained password-protected files, transcribed files on a flash drive, and secured hard-copy files. I kept one research journal that contained field notes. All procedures and protocols in my IRB application for data storage were adhered to. To remain organized, I used my private Microsoft Outlook calendar when scheduling and identifying interviews. The specified identifiers were used on all cross-references, including the interview guide and folders containing data analysis in a password-protected file. Tessier (2012) suggested to transcribe no more than 48 to 72 hours after the interview. I transcribed the interview audio tapes and conference call recordings no more than 24 hours after the interview.

Data Analysis

Consistent with Moustakas's (1994) phenomenological data analysis methodology, I took on the perspective of epoche (became aware of my personal biases), bracketed out judgments (identified data in the purest form), examined the data, and categorized the data for further identification of a structural synthesis. Specifically, I conducted data analysis within 24 to 48 hours of completing each interview followed by transcriptions and subsequent coding (Saldana, 2009). In keeping with Saldana (2009), I identified key words and I highlighted meaningful text related to answering my research questions. My primary goal of data analysis was to understand and condense the raw data into categories and themes (Saldana, 2009). This process extended to first and second cycle coding. Therefore, I assigned specific colors to themes and codes from the

interviewee responses during the first and second cycle of coding. I named each source according to the pseudonyms outlined in Table 1, as well as number identifiers outlined in Chapter 3. When I transcribed the interviews, I used the identical terminologies gathered from the participants and the testimonial notes. According to Gioia, Corley, and Hamilton (2012) it is important to treat all data with equality. I was able to equally use the transcribed interviews and testimonials to add depth and breadth to this study. Collectivity, all the aforementioned information provided insights for the basis of analysis.

First Cycle of Coding

Initially, I coded all data using Microsoft Office Navigation Pane, highlighting in bold black keywords from my research questions, literature, and SDT. The following terms were: motivation, intrinsic and extrinsic motivation, repeat offending males, domestic violence and facilitators, men and domestic violence, intervention program, cycle of abuse, male offenders, accountability, treatment programs, batterer intervention programs, DV program and development, societies and communities, workplace and wellness, and rehabilitation. I examined and summarized 20 categories as shown in Table 2. Saldana (2009) recommended that new researchers use this process of open and axial coding to become familiar with the "smaller pieces to the bigger puzzle" (p.22). To ensure that I identified the most fitting codes, I conducted a line-by-line examination of repetitive genres; placing this data in Microsoft Excel to manage this content. I then, identified nodes, which are precise references to specific cluster of words and themes

(Hart-Johnson, 2014). These high-level categories were used as multiple code types to label relevant text.

To include a more detailed analysis I used values coding, in vivo coding, and emotion coding to capture the essence of the participants. Value coding reflects a participant's values, attitudes, and beliefs, perspectives and worldview (Saldana, 2009). In vivo coding comes from the root meaning, "in that which is alive," and uses a participants' verbatim quotes (Saldana, 2009, p. 74). Emotion coding uses a participant's words that express emotion (Saldana, 2009). I coded the values codes using a small highlighted in bold black "v," "a," and "b," in vivo codes are identified by bolded quotation marks; emotion codes are identified by a small highlighted in bold red "2" before each word or phrase. The coding process and analysis was repeated until I could reduce the data into smaller controllable themes and categories. Also with coding, I created memos that described my initial thoughts about the data, and emerging analytic concepts (Saldana, 2009). These 20 combined categories were then collected as points of identifying reference leading to the second cycle of coding toward identifying themes.

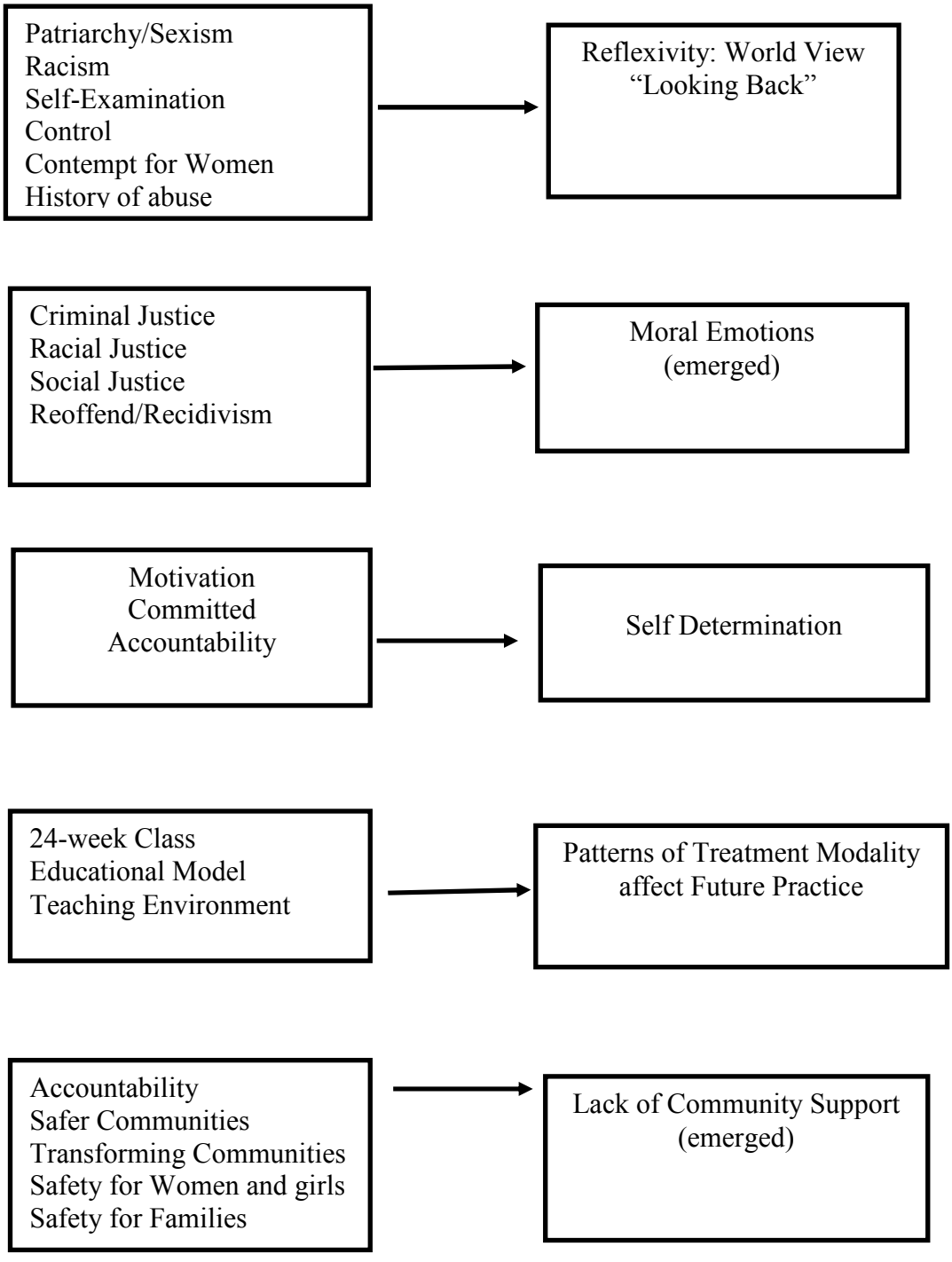
Second Cycle of Coding

Second cycle of coding assisted me to further categorize, group, and sort the data into themes (Saldana, 2009). I color-coded the participants' interview responses to identify the over-arching themes and patterns that described reflexivity in blue, moral emotions in orange, self-determination in yellow, patterns of treatment modality affects future practice in green, lack of community support in red and for any additional themes and patterns that may have a relatedness to other categories, in purple. Saldana (2009)

stated data should be cross-examined and interpret the connecting themes and patterns. Finally, with the use of mind mapping, and color-coding, I linked these themes and patterns to each research subquestion and from this process five overarching themes arose from the second cycle coding. Table 2 shows the complete codebook of overarching themes.

Table 2

Coding, Experiencing of Thematic Outcomes



Results

There are five themes, two of which emerged during the process of the second cycle coding phase: Reflexivity to World View of Looking Back, Moral Emotions (emerged), Self-Determination, Patterns of Treatment Modality Affects Future Practice, and Lack of Community Support (emerged). The primary research questions (RQ) are provided below:

RQ01: What is the essence, or lived experience of DV facilitators' motivation while administering treatment programs to repeat offending males?

RQ02: How do DV facilitators; perceive their role and motivation in the workplace?

These questions were deconstructed into seven subquestions (SQs) and assisted as the basis for interview questions as illustrated in Appendix A. These subquestions separate the previously mentioned research questions to provide a focus on specific participant responses and concepts; they will be utilized for the remainder of this study. The subquestions were varied according to new information received from the previous interviewees. All research questions aligned with the themes presented below.

Research Subquestion 01 Results

Research Subquestion 01 asked: (a) What motivates you from within yourself? (b) What other things outside of your self are motivators?

Reflexivity World View: Looking Back

According to Farrugia (2013) reflexivity is an intrinsic component that emerges from the biological makeup of human behavior and their connection to the world. Five

out of seven of the participants reported a history of some form of abuse, either as an abuser, or witnessing domestic violence within their families. This was in response to the aforementioned sub question (See SQ A1 in Appendix A). DV facilitators' answers were not classified into specific psychological or physical categories, but their combined responses exposed their lived experiences as a facilitator:

> Adam: The motivation comes from a position of… I would say unconscious in the past, and more conscious now, and this is an issue I grew up with. Witnessing abuse knowing it was in my family and within the communities,….you got to look in the mirror and examine your own history. I mean even if you never quote unquote hit a woman, you know it is a continuum, you got verbal abuse, financial abuse, and there is a whole range of possible forms of abuses that fall on the power of the control wheel. John: "…I was motivated to come here by several things that just kind of merged at once. At one time in my life. I was accused of racism at my previous job and I really wanted to learn about myself around racism."

One facilitator indicated that, men have not been taught how to channel their feelings of anger and it shows up in offensive ways. In addition to not knowing how to channel this anger, he expressed the plethora of ways this emotion of anger shows up, as well as one of the motivators that keep him committed to being a facilitator:

Daniel: I do not believe any of us came into this world with this idea of hurting people. I believe all of us as men carry a deep seed of pain for what we've done to women and what we've done to girls in our lives… and that pain… because we have not

been taught how to carry that pain, and position that pain, and that pain shows up in anger and rage and to recognize that is something all of us men have to deal with. To have a sense of compassion and empathy for men who have done some awful things in their lives, and to know that does not define them. That is who they are in this world and to talk about the possibilities, of looking at the world and seeing the world in a different way, to recognize that there is a way we can take responsibility for the things we have done. Then create a space for healing, not only for those we have hurt but also for ourselves.

During his interview, Daniel acknowledged that he knew the difference between the various levels of abusive behavior from offenders, but he did not assume a hierarchical position as a facilitator, but stated… "You see I don't see myself any different than the men there and every time I get the opportunity to be with men and talk to men, I am just as much a part of the conversation as they are." *Samuel,* on the other hand, indicated that he looked more towards the process of facilitating men.

> Samuel: I think that it feels like a valuable space in communities to be able to have a place where men come and talk about not just violence against women, but sexism, patriarchy and depression. That is what is more interesting to me, is having the platform where the opportunity to talk with men about social issues and where men would not normally want to talk about. So, it feels like the uniqueness of the opportunity is what continues to draw me towards it.

Joseph described his view inwardly and externally as a facilitator to being

connected with the offending men and his experience of the outcome that occurs during the treatment program.

> Joseph: Outside of myself, I love connecting with men. There is so few spaces like this. The beautiful thing about what I learned here as I facilitate that we really, we really engage men, we really connect with men, and we really get to the center heart of a man. What's cool about this organization is, it's real talk and kind of meeting the men where they are, but also as meeting the men where they are, we also are about holding them accountable and pushing them to do something different and find a different way.

Five out of seven facilitators reported experiencing at least one opposing psychological reaction to their past adverse choices of abuse. These facilitators reported feelings of anxiety, isolation, anger, denial, and fear.

Conversely, six out of seven facilitators reported at least one positive benefit resulting from being motivated to make an intrinsic change away from learned negative behaviors and then evolving to being motivated towards positive extrinsic outcomes. For example, Joshua reflected on his adverse choices of abuse and the impact on himself and love ones:

> The choices I made were damaging to himself and my family. When I chose to do the work such as being a participant in the treatment program, allowed me to do the work. I took the tools from that and thought that a man can only change if he is willing to change. And I knew I could not change anybody else, and if I changed me that would change my world.

Elijah, also echoed similar feelings of looking inward first:

> I actually went through the program myself and spent a lot of time acknowledging my own privilege way of dealing with my own stuff and I see the program working for me.

Samuel reported being focused and motivated more on the process of other facilitators providing better services and not so much on the treatment program itself:

> I believe the impact of being able to orchestrate this process is heavily weighted. There is value in the process and it's part of my job.

When asked specifically about his experience of being motivated inwardly or outwardly as a facilitator, he recanted, "it feels like the uniqueness of the opportunity is what continues to draw me towards it."

Chapter 5 explains what these distinctions could mean. The next section will provide findings specific to the next emergent theme: Moral Emotions.

Research Subquestion 05 and 06 Results

Research Subquestion 05, asked: Could you tell me your perspective of feeling valued as a DV facilitator?

Research Subquestion 06, asked: Please tell me how, if at all do you feel your experience as a helping professional in the domestic violence population is effective?

Moral Emotions

Moral emotions or shame and guilt may be represented as a critical stepping-stone in the process of rehabilitation (Tangney, Stuewig, and Hafez, 2011). Shame and guilt are known to be two distinct "self-conscious emotions" (Tangney et al., 2011, p.1). Shame is

linked to a person hiding or escaping and is dominant with the experience of pain, whereas guilt focuses on behavior and seeks to make amends (Tangney et al., 2011). The outcome from shame is contrary to what is acceptable in society and a direct predator of reoffending behavior. This theme answers the research questions that seeks to understand the longevity of serving as a facilitator and the effectiveness as a DV facilitator. DV facilitators' responses to the aforementioned sub-question overlap and are related to the main research questions that asks about DV facilitators' motivation in the workplace, and motivation while administering treatment programs to repeat offending males.

For example, some DV facilitators reported feeling the challenge of effectiveness is not in the treatment program itself, but in the process of the justice system.

> Adam: …Since we see this problem as a community problem, and not one individual man, can measuring individual men outcomes be flawed? … okay let's just start there, here's why, … What outcome measures we tend to use, measure effectiveness of a program? It is usually recidivism,…right? And one way recidivism is measured is after a year, two years, or whatever period of time did he reenter the system, in this case the criminal justice. …did he reoffend? Usually it is a criminal justice measurement because we know a lot of men who are reoffenders.
>
> John: So the program that connects the community and men,… there is not outside funding for it. So, if you have a batterer's Intervention program both the men pay and you know there is some other resources we can get, sometimes on a state level to help pay for some stuff in the batterer's intervention. We've not

found a good funding source for the program that connects the men back into their perspective communities and so I'd say yes I do feel supported in it, but on a organizational level it doesn't generate income, and so therefore it can be kind of… um received less focus than other areas. You know our training is high profile, you know the work we do with men in the classroom is high profile, … it's high quality and has funding streams for it…whereas this doesn't.

Daniel: So, my thoughts about the effectiveness of the work that I do are, when men come to us in a very hurt place, they've been hurting for a long time. …I believe that our demonstration of control, power, and dominance that once we've done something we recognize that pain, we recognize what we've done, we don't know how to talk about the fear, the anger, the uncertainty's, the inadequacies, the things, … we don't know how to talk about it, we have never been given a script so we show up with rage and anger. So, what I believe is that in doing this work either is that men begin to recognize that it is a whole other part of me, that I have not allowed to grow in me. I need to be in touch with full humanity, in turns of being in touch with all of me and not just the rage or the angry part of me.

In addition to DV facilitators feeling valuable within their organization, one of the facilitators identified feelings of guilt when initially having to partake of the treatment program as a participant and not as a facilitator.

John: you know I think, sometimes I think this organization facilitators do a good job, but sometimes men, when we go through the program feel a tremendous amount of guilt…yea, there are different kinds of guilt, you know, there is both

productive guilt, … like wow I really hurt people I cared about, I want to change, and then there is toxic guilt around I'm awful, I'm a horrible person, you know I'm never going to fix this kind of stuff, and so, you know I felt some of that toxic guilt and also the regular guilt at the beginning. So you know it's just the time when kind of my world got kind of turned upside down um the advantage was there is a group of men here that I could connect with and stay connected to that cared about me, but also held me accountable, …um and so you know even then when I was upset, and shaken, I was also very attracted to how can I be part of this group of men that will care about me, but hold me accountable for my actions.

Another facilitator described how valuable he felt as a facilitator, as well as feeling his work is effective only if the tools learned in the treatment program are utilized.

Joshua: I kind of start that motivation process with them and then encourage. … help them not only want this for themselves, not just for their micro community, or their macro community but for society as a whole. …You know that is an amazing feeling. And I know that this work, cause I used myself as an example. I was one of the worst individuals I had ever met in my life. You know when I was given the opportunity and was offered some really powerful tools, I applied those tools and I applied them to myself over and over again, and then they became second nature to me and it totally counteracted,… you know totally opposed the behaviors I had before, because of the tools that I now have. I know effectiveness

> now because I use it in myself and in my daily life. You know it used to be people did not want to talk to me, and now people pay me to talk to me. So, now there is a huge difference, I didn't change anybody else I just changed me.

Although, the facilitators described both aspects of feeling valuable and effective, very few reported having a positive experience with a follow-up in place when the men matriculate back into their communities.

Research Subquestion 03 Results

Research Subquestion 03, asked: Please tell me how do you feel about your ability to provide the best services you can?

Self-Determination

The aforementioned research question is answered through the theme: Self-Determination. The responses from the participants reported feelings of determination to serve in the spirit of excellence and commitment to continue to provide rehabilitative services for offending, and reoffending males. For example, *Samuel* provided experiences of providing the best services he can in the domestic violence organization:

> I think in general, …I think our culture as an organization, values that role. Like I said, it's a small part of my job, but it's an important part of my job because it's what keeps me grounded… and so I think we make the resources available for me to do it. Because it's not just important to the community, but it's important for this organization to continue that work, … determination, it's not what we want to be most known for, but it is what we are best known for. It's a training ground,

it's a place that I improve my skills in engaging men… and so I think it's valued across the organization.

Elijah: I actually in this area,… I feel pretty confident about it. One of the things that I am aware of kind of having done my research and having talked with advocates around domestic violence issues, around various parts of the country. This organization is really at the forefront of this work with men and batterer's intervention groups and this organization trained me, … and kind of affirmed me along the way, and encouraged me. So, I really feel very confident and determined in my ability to sit down with a group of men and facilitate well because of the training and experience this organization gave me as well.

John: I think the men we have in the classroom are facilitators that have gone through the program themselves. So that seems to me a very important piece of feeling determined that I and the other men have done our work on ourselves, and its' an ongoing process so, it's not something you can do in a 24-week program and then jack you're done. But, at least there's that level of introspection and you know of not saying it's those men and we are above them but we are all men and we all have gone through it.

Joshua: Well, I'm very fortunate with the program and the facility. The first thing I did was go in there about a month and sit in on the groups, and then I took the facilitators training. I put myself into a 6-month program as a client, … as a student as it is worded, … and it gave me an opportunity to see the co-facilitators interaction within the groups because they always had co-facilitation…. I was

very fortunate to sit in with one of the directors for a two-month period of just watching the facilitation of classes. … and then I got invited in to co-facilitate. I did 93 hours of co-facilitation which help set me up to be the best facilitator I could possibly be and determined to give the tools possible to those in and around my community.

Daniel: it's really important I also realize in the years I worked with this organization, I had an opportunity to intervene with thousands, I mean thousands of men. I mean not just here in the United States, traveling to other countries outside the United States, and having the opportunity to teach and educate about what it is to create communities that are safe for women and girls. And also, I've been in 44 states in doing this work and so I realize that there is still a lot of work that needs to be done….and that work can be done.

Joseph: as a facilitator is to steer the conversation to make sure we are doing work. Depending on what's coming in the room always making sure that we are doing work and that there is some purpose to what we are doing. That we have a goal,…so, I think that is a part of my role.

Adam: I know the founders of this organization are still around. …and so I know the story, how this organization got started and these were men, who were involved with the Civil Rights Movement, seeing they were doing social justice work,… and the issue of violence against women is very raw for them, so they actually have that lived experience and they were owners of this,…a lot of this work again for a lot of us is personal and we are determined. I think anyone who

> is in the helping professional are not perfect, we have stuff, you know like history that drives us to want to make a difference in the world,… cause we know what it was like; that experience of determination.

The facilitators in the sample indicated their self-determination was stemming from an innate drive that surpassed the level of expectancy or support from the social justice system, or the lack thereof.

Research Subquestion 02 and 04 Results

Research Subquestion 02, asked: Could you share how often you are expected to facilitate these programs? Daily, weekly, monthly

Research Subquestion 04, asked: May I ask how long have you served as a helping professional, particularly as a DV facilitator?

Patterns of Treatment Modality Affect Future Practice

The aforementioned research questions are answered through the theme: Patterns of Treatment Modality Affect Future Practice. The facilitators conjointly experienced the affect from the educational modal that encompasses the 24-week program of positivity. The educational model looks into the global aspect of the man.

Joseph, found positive psychological benefits when having to motivate men through their treatment program. He indicated he is always uplifted when "men show up and do the work." Daniel also reported feeling empowered to experience "gratification and appreciation," when the men display how they are benefitting from the 24-week program. He stated, " I've done this work for nine years. I believe we instill in men the skills the knowledge that ability to make choices, in terms of what they do with that, it is

up to them." *Adam* expounded upon his experience while implementing the 24-week programs:

> You know, it would be disingenuous to you, to deny that there are a couple of therapeutic benefits, you know to the educational model right, so it's not a semantics. But, beyond semantic in some way. It is very real that if we are to end violence against women how would we define the problem?..For the past 22 years I've been in this line of work, I noticed we are expected to determine the kind of solution…. Right? … we have to share the different problem. So, we were clear when the owners came to do the work a very "from a social justice lens, and it was not an easy shift for everyone. This is not a problem of individual men gone astray, this is a social community problem, rooted patriarchic, rooted in contempt for women. Men learn to have contempt for women. "This is not about a psychological deficiency that required some therapeutic intervention because this is learned… and this is learned well. Even if you had a 100.00 dollars plus batterers intervention program, intervention for men across the country, and Canada, only a small percentage of men are going to those programs, or those that get caught. Think about it, right who really gets caught.. black men, brown men, and poor men in the criminal justice system. So, it's a misrepresentation of who these acts of violence are against, you see the court class, it is predominately African American and brown men.

Research Subquestion 07 Results

Research Subquestion 07, asked: Could you describe some success stories as a DV facilitator?

Lack of Community Support

DV facilitators responses detail the apparent disconnect from the intervention programs and the process of matriculation of men back into their perspective communities. Their answers to the aforementioned research question can be found in the description below. For example, Adam provided a descriptive overview of this separation:

> We see this problem as a community problem, and not one individual man. One way recidivism is measured is after a year, two years, or whatever period of time did he reenter the system,… in this case the criminal justice, did he reoffend, and usually it is a criminal justice measurement, because we know a lot of men who are reoffenders. But, they are not in the system, right, and their family member may call them out. Family may not even know about it. But, usually the criminal justice system is full of recidivism. Because a man does not end up back in the courts, does not mean he is not abusing her anymore. So, it's a small matrix. So, because the question is, how do we know he is not abusing her. The only way to really know that is, if she reports and she is in a place to safely say, here is what is going on. So, it may be a follow-up with a phone call, text, something written, but often times he may be intercepting her email, picking her phone calls. We may do phone interviews, you got to make sure she is really, really in a place to provide

that and we hardly do any kind of research that interviews the women in a safe place, to hear their story and that's the only way to measure effectiveness. Is she safe to say "yea he's not doing it anymore." Let's say if she is in a room like this, and he is in the way. That is part of his management of her, if he intercepts her mail, manage her where and here abouts. Tell me about any research that is doing that. That is speaking to survivors, criminal justice, recidivism, there is not a program completion, an apparent program completion, that has a protected effect; Um completion of the program, it seems as a positive indication of a man that's likely to abuse…. Alright, so he completes the program that is protective. The problem again with that is how do we know what receives a value, if a man goes through a 24-week program, he would have been exposed to a lot of information, he is less likely to reoffend, I get that. But, that is another measure of research that is completion of programs, I mean I could go on and on about individual metrics that if we enforce an identity problem of individual men. The problem is they fight and end up assaulting women, and end up back in any type of treatment. They're looking to learn, they're looking to the message from the community., to the extent, in terms, if they can get away with it. If the community says this is not acceptable, the church acts accordingly, the employer acts accordingly, the media get active, all the systems are saying, "NO," men have told us in the 30 plus years we have been doing this work that, they're less likely to do it. Why do we do it? Because they can. For the most part, they had gotten away with it. They expect, they can, when she comes forward and say I've been

> harmed, that's one of the first thing that is said, "Oh my God, what did she do to provoke that man, why didn't she leave, that is the seventh time she went back with him. Totally focused on the victim, instead of saying why is he allowed to get away with it." Victim blaming, and then it worked, he gets what he wants, and then we see this learning cycle continues.

DV facilitators reported being committed to provide quality treatment programs to repeat offending males. They are required to follow steps of obtaining approval from the state of Georgia. Once this approval had occurred, this organization began to implement the 24-week rehabilitative process identified through the educational model. Although, it appears this program is effective from the facilitators' perspective, there is an apparent disconnect with the emerging themes of Moral Emotions, and Lack of Community Support. DV within itself is significant to the continuous cycle of separating the family unit. The facilitators noted their feelings of passion that exuberates their drive to serve repeat offending males. Daniel exclaimed:

> It's not about fixing the men, but coming together with the communities and create severe stipulations for men that choose to abuse.

Research question 01, coincided with subquestions 02, 03, 04, 06, and 07. Understanding the essence of intrinsic and extrinsic motivation of DV facilitators lived experiences while administering treatment programs to repeat offending males was the background of this study, only one facilitator expressed the focus on his ability to provide or train facilitators was his main concern. In contrast, he believed in the tools provided through the educational model of the treatment program as a productive rehabilitative

measure based on his personal experience as a participant. Understanding intrinsic and extrinsic motivation was a consensus of agreement of being suitable for rehabilitation. However, the rehabilitation is viewed as "working," only if the tools learned are implemented on a daily basis from the repeat offending males. The facilitators reported if a man has been sanctioned with DV, and is court-mandated to attend either the one 3 ½ class at the courthouse, or 24-week educational rehabilitative class, they have to be willing to actively engage and participate in order to make a change, as well as receiving credit for attendance. Five out of seven participants experienced DV as the abuser, or witnessing abuse in their families. Seven out of seven participants were required to take the 24-week course as a partaker in the class prior to being considered as a facilitator. Daniel stated: "It gives a sense of you have to feel it to heal it experience." Because each DV facilitator described elements of acknowledgement of their lived experiences their lives were changed in a positive manner by simply adhering the same things they require of the repeat offending males to do; unlearn reactive behavior and learn controlled and managed tools to be socially acceptable. I will discuss this more in chapter five.

The second research questions coincided with subquestions 01, 02, 04, and 05. Perception can be a powerful tool when viewed through the lens of reality. The participants provided great insight into seeing their experiences as facilitators valuable. Collectively, whether they feel their roles as DV facilitators' is crucial to offenders; they understand the importance of never appearing as the authority in the process, but as an equal, working towards healing. For example, Joshua offered:

A participant revealed how it keeps everyone grounded and always providing services with the same amount of compassion you would be expecting to receive.

Discrepant and Nonconforming Data

The testimonial notes used for this provided perspectives and ways to look thoroughly at the data. Eight testimonials maintained a consistency of the quality of the program and the rehabilitative position of empowerment it provides. It also depicts a strong consistency of motivation intrinsically and extrinsically. For example, a court official reported, "I believe that the work I saw made a significant contribution to personal and community safety in the lives of their clients, and I try to bring what I learned to the work I do every day."

Evidence of Trustworthiness and Credibility

I maintained trustworthiness and qualitative thoroughness by following thoroughly the identified research protocol outlined in my proposal and IRB application. This process included: implementing document management practices, intuitive balanced of bracketing of my biases, through the use of memos, engaging in field work by conducting seven interviews, using multiple data sources, performed member checking when necessary, and sought guidance and advice from my dissertation chair and doctoral peers.

The usage of memos were used utilized as a means of reflection and thought processes for intuitive bracketing. Member checking was accomplished in two ways: I paraphrased interviewee's responses and summarized some of their statement during the course of the interview, for the sake of accuracy of interpreting. I sought peer feedback

on my coding from fellow doctoral students for accuracy. Finally, I checked in with my dissertation chair to elicit feedback.

Transferability, Dependability, and Confirmability

In achieving transferability, I created detailed descriptions of participant stories to support my interpretations of the data. The depth and extensiveness of the data was gleaned mainly from the interview process. To carefully maintain the authenticity and dependability of the participants', I used in vivo coding, I utilized a semi-structured interview, which provided a foundation and autonomy from the participants' perspectives in reducing biases and maintaining the focus on the researched phenomenon. Birt, Scott, Cavers, Campbell, and Walter (2016) reported member checking is the bedrock of trustworthiness of results and adding dependability. I verified clarity with the participants during the interviews to ensure accuracy during transcription. Finally, for confirmability, I established an audit trail by adhering to the protocol outlined in my IRB data collection steps and research outline.

Summary

In this chapter, I provided an overview of the research setting, the interview process, participants' profiles, and specific data sources. I provided participants in vivo responses to the research questions through the five major themes identified during data collection and analysis. I presented these themes as they originated from initial codes. Testimonials were discussed, and the study's trustworthiness, credibility, transferability, dependability, and confidentiality were distinguished.

In Chapter 5, I present my interpretation of the findings. Thematic findings are explained and they are in sync with Chapter 2, as well as the proposal stage. This study's limitations, recommendations, and implications are discussed. In conclusion, I offer concluding thoughts and this study's contribution towards positive social change.

Chapter 5 Discussion, Conclusion, and Recommendations

The purpose of this qualitative study was to explore the experiences of DV facilitators regarding their intrinsic and extrinsic motivation while administering the same treatment program to males who displayed reoffending behaviors without any evidence of change. I sought to explore what, if any, responses were consistent with motivation. A hermenutic phenemonological design was best suited for this study because it allowed me to capture the lived experiences from the lens of the participants. This study built on research by Ryan and Deci (2000) who explored motivation using self-determination theory (SDT) to identify intrinsic and extrinsic motivating factors. Althoug Ryan and Deci added to the body of research, I identified a research gap, which was understanding intrinsic and extrinsic motivation of DV facilitators when administering the same treatment program to repeat offending males.

Overview

Participants in this study included seven self-identified DV facilitators. I used semistructured interviews to collect data. I also followed a hermeneutic phenomenological design including additional data sources for triangulation purposes. The main research questions (RQs) are provided below:

RQ1: What is the essence or lived experience of DV facilitators' motivation while administering treatment programs to repeat offending males?

RQ2: How do DV facilitators perceive their role and motivation in the workplace?

The main research questions were expanded into seven subquestions so that each concept could be thoroughly examined according to the new information received from

each interviewee's responses. These subquestions were answered via the findings presented in Chapter 4. The outcome from this study revealed that many DV facilitators have personal experiences of abuse either as an abuser or witnessing abuse within their families. Their passion to provide treatment through an educational model in which they had previously participated as clients was a finding of intrinsic motivation in action. Many facilitators experienced outward satisfaction, accountability, encourgament, and support from the other offenders within the treatment program, which increased their motivation of being an active part of creating safer communities. Two out of seven facilitators reported their personal shame and guilt from their previous actions as motivators to keep them functioning as DV facilitators for reoffending men. This next section provides interpretations and plausible alternatives to these findings.

Interpretation of the Findings

In comparing the participants responses with the literature review, this study confirmed that SDT describes the insight of intrinsic and extrinsic motivation and outcomes with DV facilitators. Intrinsic motivation focuses on the mere enjoyment of a process and outcome, and extrinsic focuses on the gains and losses of a process and outcome (Cerasoli et al., 2014). This theory explains the collated themes of how DV facilitators described their perceived experience of feeling valued in the workplace, and day-to-day duties of providing a service to repeat offending males, without measurable signs of rehabilitation.

Research Subquestion 1 Findings

Research Subquestion 1 asked the following: What motivates you from within yourself? What other things outside of yourself are motivators?

Reflexivity World View: Looking Back

SDT is used to describe concepts of intrinsic and extrinsic motivation for human beings' development and wellness (Deci & Ryan, 2008). Haggar et al. (2013) and Deci and Ryan (2008) emphasized types of motivation and not soley amounts of motivation, using autonomous motivation, controlled motivation, and a-motivation as prognosticators of performance and overall well-being. SDT is also used to look into an individuals' life goals; cognitive, social, and physical development; and aspirations showing variance relations of intrinsic and extrinsic life goals to performance and psychological health (Deci & Ryan, 2008). There are also notable differences obtaining a perceived innate drive of motivation that will change an action (Deci & Ryan, 2008; Haggar et al., 2013). Reflexivity is the theme used to provide a deeper understanding of how individuals relate to themselves, their previous experiences, and the work they have done on themselves in the world (Farruga, 2013). Both SDT intrinsic and extrinsic motivation and reflexivity appears to coincide with an action in the wider social world.

When comparing intrinsic and extrinsic motivation and reflexivity, I was consistent with SDT intrinsic and extrinsic motivating factors. SDT is measured intrinsically through free choice and self-reports of interest and enjoyment of activity (Reiss, 2012; Ryan & Deci, 2000). Also, this motivated change is extremely valuable due

to its production of consequences with DV facilitators' leadership roles that are responsible for mobilizing others to act (Lee et al., 2014; Ryan & Deci, 2000).

The participants discussed boundaries that were important when functioning in a leadership capacity; however, to promote accountability, the DV facilitators related to the offenders as being on the same team. For example, experiencing compassion and accountability as a partaker of the 24-week treatment program motivated the facilitators' to provide this same experience to male offenders. They expressed pride in their ability to be committed to this work of rehabilitation and not so much on an individual's outcome. Joseph described the full cycle of safety beginning with an inward motivation to change and ultimately involving his entire family unit. Based on his understanding of the cyclical phase of DV actions, Joseph reported that it was important to remain connected to the men in their communities for support, accountability, and consistency in applying the rehabilitative tools. Other DV facilitators shared the same perspectives. Elijah reported that "becoming a facilitator through this organization I actually went through the program myself and spent a lot of time acknowledging my own privilege of dealing with my own stuff, and so I see how the program worked for me." John described his experiences as "feeling motivated, to make a change in my personal life, to initially save my marriage and ultimately save my life." These reflections from the DV facilitators pointed to SDT and being intrinsically and extrinsically motivated to serve as a DV facilitator and not focus on the frequency of reoffending males who matriculate in the treatment programs, but on how many offending males begin to rise up and apply the tools learned toward rehabilitation.

Research Subquestions 2 and 4 Findings

Research Subquestion 2 asked the following: Could you share how often you are expected to facilitate these programs? Daily, weekly, monthly? May I ask how long have you served as a helping professional, particularly as a DV facilitator?

Patterns of Treatment Modality Affects Future Practice

Findings indicated that the application of DV treatment programs is part of the process toward change. Cantos and O'Leary (2014) argued that a one-size fits all treatment program is not conducive to reducing repeat-offending behavior. Men who are sanctioned for DV behavior are usually mandated to attend a treatment program as a part of the community response (Cantos & O'Leary, 2014). Cantos and O'Leary also noted that in 5% to 20% of offenders, recidivism rates increase. DV facilitators reported that they refer to DV treatment programs as batterers intervention programs. Adam reported "there is not a program completion that has a protected effect."

The findings of this study provided insights into how DV facilitators experienced the effectiveness of the treatment program educational model prior to becoming facilitators. They expressed the experience of being in a teaching environment replete with compassion, which allowed them to develop the trust and the courage to want to begin with a focus on their own work before attempting to educate other offenders. One DV facilitator expressed his feelings of knowing he had to make a change because he did not like himself.

The current study's findings also aligned with moving offenders into observation of their parenting styles in reducing their abusive behavior (Cantos & O'Leary, 2014).

Some DV facilitators reported one of their programs toward rehabilitation is bringing together the offenders with their daughters through educational activities. This class is solely focused on building skills and strengthening what remains of the family unit. Based on DV facilitators' accounts of their experiences, the importance of being prepared to do work when coming to the batterer's intervention class is imperative to beginning a new cycle of decision-making. Each participant reported that around the 12th week of the 24-week batterer's program, there is a transition that occurs and the work begins towards rehabilitation by beginning with accepting responsibility for one's own abusive action and wanting to use the learned tools from the education model.

This study did not confirm the assumption that DV facilitators were likely to feel a challenge with the treatment program. I examined the coded data through the lens of self-determination using SDT (Ryan & Deci, 2000). I found that most DV facilitators in this study described the treatment programs as a "great way to stop the blame game and for the first time, take a look at yourself and unlearn learned negative and destroying behaviors." Daniel reported "when we talk about treatment, when we talk about groups, when we talk about counsel, we're stepping over in the area of therapy and counseling. I prefer to think of the work we do as educational; we are teaching and educating men to know that change is possible for them, by giving them and informing them of information they have not received." The findings also supported the claims of Mennicke et al. (2015) and Veeh et al. (2015) who indicated that effective treatment programs that educate men and decrease levels of criminal thinking may increase positive thought processes toward women and reduce reoffending behavior.

Research Subquestion 3 Findings

Research Subquestion 3 asked the following: Please tell me how you feel about your ability to provide the best services you can?

Self-Determination

Findings in this study aligned with the literature discussed in Chapter 2 that indicated that accountability, motivation, and commitment reinforced self-determination. Two of the DV facilitators reported they had served in this type of work for many years. Daniel reported that he would continue to spend his time educating men on how to be determined, accountable, and committed to understanding what is going on and how this cycle continues, and then "make a different choice in that space." Adam had also spent a significant amount of time serving this population. He described the essence of determination to be "a little better than we were the day before." Both facilitators indicated that providing a space that would allow offenders to examine the damage that is directly linked to their choices and then educating them on the importance of change is "priceless."

Research Subquestions 5 and 6 Findings

Research Subquestion 5 asked the following: Could you tell me your perspective of feeling valued as a DV facilitator?

Research Subquestion 6 asked the following: Please tell me how, if at all do you feel your experience as a helping professional in the domestic violence population is effective?

Moral Emotions

Moral emotion was an emergent theme that appeared during the second cycle of coding. Moral emotions such as shame and guilt are a critical stepping-stone in a rehabilitative process (Tangney et al., 2011). Hart-Johnson (2014) indicated that guilt serves two purposes: "self-critique, and a catalyst for change" (p. 189). Shame is associated with high rates of reoffending behaviors and humiliation (Tangney et al., 2011). Tangney et al. (2011) suggested that moral emotions are "here and now" factors amenable to intervention. Moral emotion sentencing connects with community sentencing where trained facilitators assist with restorative justice sentencing in allowing DV offenders to see firsthand the potential or actual destructiveness of their infractions (Tangney et al., 2011). This exposure may generate feelings of behavior-focused guilt, which may promote constructive solutions (Tangney et al., 2011). Study findings indicated that DV facilitators who felt the co-existing presence of guilt were motivated to move toward a better outcome for themselves, their families, and their communities.

Research Subquestion 07 Findings

Research Sub-question 07 asked the following: Could you describe some success stories as a DV facilitator?

Lack of Community Support

In this study, lack of community support was another emergent theme that occurred during the second cycle of coding. DV facilitators discussed the importance of linking the community with DV organizations, so when the male offenders are matriculating back into their perspective communities, they have a support system that

provides accountability. For example, five out of seven DV facilitators' expressed some disconnection from the community and DV offenders as they are released to return to their homes. Some DV facilitators expressed, the community appeared to have a silent consensus of, "Oh send them over there to be fixed." Transforming communities was the reappearing experience from the DV facilitators.

Limitations

It should be noted that the findings of this study are based on a small sample, (n=7) of DV facilitators. While my conclusions are based on this small homogenous sample of DV facilitators, these DV facilitators are considered subject matter experts. There is evidence that this study's design should be applied to additional DV organizations, different gender groups, and the criminal justice systems. Although a small sample is distinguished limitation, it is important to acknowledge that the purpose of this hermeneutic phenomenology study was to capture the core essence of the lived experiences from the DV facilitators' experience through SDT and the exploration of intrinsic and extrinsic motivation while administering the same rehabilitative service to repeat offending males, without evidence of change as a foundation for future research. Hart-Johnson (2014) suggested qualitative samples are "intentionally small to provide a wide depth and breadth of participant experiences" (p. 216-217).

Another possible limitation of this study is that research participants were asked directly, could you describe some success stories as a DV facilitator. It is possible that facilitators cannot really measure success because DV offenders are not at the demise of their rehabilitated progression. Future research may consider not asking the question

using the word “success”, to determine if results would be consistent with this study’s findings.

Finally, a limitation is that three of the interviews were conducted via private conference call rather than in-person Thus, any non-verbal reactions and in-person observations could not be recorded. Consequently, I was able to make notes of sighs, and emotions, such as laughter and elevation in their tones due to excitement while discussing the subject matter. Hart-Johnson (2014) suggested there is a sense of privacy and security of the interviewer not exemplifying nonverbal ques that could pose judgements.

Recommendations

Based on the accounts of DV facilitators detailed in this study, a lack of apparent support from the community may delay the progression of repeat offenders from rehabilitation. My analysis reveals there is a disconnection with a strong accountability of community support physically, psychologically and monetarily. Also, the enhancement through participatory action research (PAR) (Hart-Johnson, 2014). PAR researchers identify the “oppression of specific groups and engage the individuals and stakeholders in a collaborative examination of program design, gap assessment, and collective identification of solutions, and then validate it through empirical research” (Hart-Johnson, 2014, p. 219). Ideally, PAR is beneficial due to the upholding of ethical guidelines of confidentiality and protection as it relates to research (Hart-Johnson, 2014).

Future research should include quantitative experimental research using, intervention group, and a control group to determine whether the presence of strong community support helps to restore a sense of normalcy to males who struggle with

abuse. Considerations should be given for future research to include a qualitative approach with DV facilitators lived experience with offending and repeat offending males with restorative justice.

Another area that should be considered for future research is to explore how females DV facilitators experience facilitating treatment programs to offending and repeat offending females. Given that women are offenders is an indication there are other populations that could benefit from this focused research.

Finally, it is reasonable to recommend that social change program developers consider incorporating strategies to change policy within the criminal justice system and reconsider increasing DV sanctions to a possible mandated 24-week batterer's program, with a mandated community linkage for a minimum of two-years. Support may include the entire family unit being provided a resource guide to include information specific to treatment programs for the entire family, mental health support, and effective communication strategies. Hart-Johnson (2014), suggested when society fails to recognize adversity in the community, it is an empathetic failure. Therefore, the recognition of this being a social problem should be adhered to and a plan of action towards change should occur.

Implications

One of the predominant findings was that intrinsic and extrinsic motivation is a direct connection to consistently administering DV treatment programs to repeat offending males. Findings from this study provide an opportunity to extend the relevance of examining the entire process from the DV sanction to reunifying the family unit.

These findings may be applicable across-disciplines and specialty areas, including, but not limited to public health and safety, criminal justice, health and human services and psychology researchers. This change is disseminated through advancement of a phenomenon as equally agreed upon by the research community as a challenge, yet a problem solving initiative that is substantiated, valuable, significant, and imperative.

Positive Social Change

This study was conducted with the goal of positive social change as the driving force towards purpose. During this dissertation, I sought, first, to understand the social problem of domestic violence, second to choose a section that appeared manageable, yet significant towards an outcome that will positively affect the reunification of the family unit, and third to bring awareness from the DV facilitators' perspective voice of reducing reoffending abusive behavior. One of the findings of this study is that there is an apparent disconnect with community supporters and a perceived laissez-faire criminal justice policy towards sanctioned DV offenders. This perceived lack may continue to hinder possibilities of recovering from the experience of domestic violence, fear of reoffending behavior, and continued breakdown and separation of the strength of the family unit. Therefore, as my social change initiative, is to begin with the criminal justice system and provide them with information and resources specific to the findings from this study that may help to recognize this perceived laissez-faire approach toward rehabilitation of offending and repeat offending males. My social change goal is to ultimately provide information and resources to various community organizations (i.e. local faith-based

institutions and community mental health agencies) to improve their connection and accountability to repeat offending males as they re-enter their perspective communities.

Second, I plan to disseminate this study's findings to the research community, professional and legislative conferences. This distribution is essential to raising awareness of the implications of DV facilitators lived experiences while administering DV treatment programs/batterer programs to repeat offending males, without signs of rehabilitation. The context of hermeneutic phenomenology in participant stories may assist to provide direct insights to create a scholarly discussion on how to best improve or at the very least reduce the potential damaging impacts of domestic violence on the strength of the family unit.

Researcher Reflections

During this research study, I learned how this hermeneutic phenomenology method could be used to uncover a significant amount of understanding of participants' processes, actions, and outcomes. This method also allowed me to become fully-present and absorbed in the data where I understood the processes, as well as connections that formed the thematic codes. I found that being engulfed with the literature prior to the study transformed me so that I was able to have theoretical awareness. This study's conceptual framework not only guided this study, but also prevented me from crossing any boundaries.

Finally, the most amazing and honorable experience was to be allowed to sit with subject experts and be enlightened through the participants lived experiences. These DV facilitators believed in the potential of being a partaker of creating a voice of awareness

towards a continuous positive social change. They freely expressed their hearts concerns, and challenges without any hesitation.

Conclusions

It is my belief and understanding that change is inevitable for those that have a desire and courage to transform. This study offers an opportunity to pursue these entities. For example, DV facilitators were found to intrinsically and extrinsically be motivated to remain committed to facilitating the same treatment program to offending and reoffending males due to the focus being on educating, support, empathy, and accountability. Therefore, it is important for everyone in the helping professional to understand the need for a complete cyclical connection to all the components of the rehabilitative process, for repeat offending males through legislative, community support, continued implementation of education surrounding the batterer's program, and empirical research. Adding a more pivotal voice towards change will unequivocally resurrect the belief, strength, and structure of families nationwide. So, let us begin with the willingness to unlearn those things that create havoc and destruction in this nation, learn, and implement what it takes to be the strength that remains, pushing towards a presence of power!

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Appendix A: Interview Process

Domestic Violence Intervention Program Facilitators' Motivation for Working with Repeat Offenders

For the Participant: This research is focused on your experience and feelings while administering the same domestic violence treatment program to repeat offending males. In maintaining this focus of your experience, please do not use any specific details that will identify any of the DV offenders' case, or criminal sanction, as well as talking about any of their pending criminal investigation.

Research Question	**Opening Questions**
RQ02: How do DV facilitators perceive their role and motivation in the workplace?	A). Thank you for your time and choosing to be a part of this interview. Are you ready to get started? If so, as just discussed, we are here to talk about your experience as a Domestic Violence Facilitator and the motivation you feel to administer continually, or facilitate the same treatment program to repeat offending males; with no signs of rehabilitation. **Subquestions A1:** What motivates you from within yourself? What other things outside of yourself are motivators?

RQ01: What is the essence, or lived experience of DV facilitators' motivation while administering treatment programs to repeat offending males? **RQ02:** How do DV facilitators perceive their role and motivation in the workplace?	B) Could you share how often you are expected to facilitate these programs? Probe: daily, weekly, monthly, etc.?
RQ01: What is the essence, or lived experience of DV facilitators' motivation while administering treatment programs to repeat offending males?	C) Please tell me how do you feel about your ability to provide the best services you can?
RQ01: What is the essence, or lived experience of DV facilitators' motivation while administering treatment programs to repeat offending males? **RQ02:** How do DV facilitators perceive their role and motivation in the workplace?	D) May I ask how long have you served as a helping professional, particularly as a DV facilitator?

RQ02: How do DV facilitators perceive their role and motivation in the workplace?	E) Could you tell me your perspective of feeling valued as a DV facilitator?
Research Questions	**Closing Questions**
RQ01: What is the essence, or lived experience of DV facilitators' motivation while administering treatment programs to repeat offending males?	Please tell me how, if at all do you feel your experience as a helping professional in the domestic violence population is effective?
RQ01: What is the essence, or lived experience of DV facilitators' motivation while administering treatment programs to repeat offending males?	Could you describe some success stories as a DV facilitator?
	Do you have any questions for me?
	Are there any questions, you feel I should have included within this interview?

Closing the Interview/Debrief

- Provide an explanation of next steps of the research process
- Explain and reiterate confidentiality

- Read and provide a copy of a referral list
- Identify all of Walden University's contact information on the informed consent
- Discuss the details of the research report
- Thank the participant again and receive additional information for follow-up purposes, and end the interview
- Check and label the recordings
- Document any additional notes.

Appendix B: Demographic Screening Questionnaire

Domestic Violence Intervention Program Facilitators' Motivation for Working with Repeat Offenders

Interview Identifier: _____ Date: _____

This form will provide the screening process for potential participants, for the assurance of meeting criteria befitting for this study.

During this research study, the attempt to reduce any said risk to human subjects will be adhered to. Within my research study, it has a focal point on individuals that are appropriate adequately to answer the research questions within the interviewing process. The interviewing proces will be be conducted in a nonintrusive manner. I would now like for you to answer a few questions for this determination. If you are a great fit for this study, you will participate in an interviewing process to elaborate on the core for this research study.

Read to the Participant

1. The willing participant must be 18 years of age, and proficient English speaking,
2. To be a participant, you must be actively facilitating DV treatment programs to repeat offending males.
3. You must be employed with Men Stopping Violence as a DV facilitator.

You cannot participate if you do **not** meet all 3 of the criteria above.

If you do qualify and would like to be a participant in this research study by being interviewed, I will schedule the interview. When meeting for the interview, I will discuss

further the details from the informed consent (provide an explanation of informed consent).

Appendix C: Recruitment Flyer

Doctoral Research Study

Domestic Violence Intervention Program Facilitators' Motivation for Working with Repeat Offenders

Are you a domestic violence facilitator that administers treatment programs to repeat offending males? If so, please consider an interview with me to share your experience; in a private, confidential manner.

This study will focus on understanding the internal (intrinsic) and external (extrinsic) motivation of administering treatment programs to habitual offending males.

Participants are asked to:

- Pre-screen
- Provided Informed Consent (granted permission; including the acknowledgment of any risks and benefits. Audio Taped interviews
- Confidential 30-60 min. In-Person or toll-free telephone interview (5-15 minutes)
- Meet at agreed upon location
- Share your experience about motivation
- Note: Voluntary Participation: No compensation

Contact the Researcher
Name: Elaine M. Barclay
Walden University
E-mail: elaine.barclay@waldenu.edu

Side 2

Are you a good fit for this study?

- The willing participant must be 18 years of age, and proficient English speaking,
- To be a participant, you must be actively facilitating DV treatment programs to repeat offending males.
- You must be employed with Men Stopping Violence as a DV facilitator.

What motivates you to administer the same domestic violence treatment program to repeat offending males?

****A study about intrinsic and extrinsic motivation when faced with the same action, with no signs of change.**

This location of this flyer has no affiliation with this study

I will be the only recipient who will access the raw data. Transcription and final summarized research study will be available upon request

Appendix D: Community Resource Guide

Mental Health Resource Guide Updated January 2012

MENTAL HEALTH Directory

Where To Go, What To Do, Who To Call

To Obtain Free and Low Cost Mental Health Services

Date: January 2012

Mental Health Resource Guide Updated January 2012

<<<<<>>>>>

"For the majority of us, the essential question and task remain: What can we do that will help us understand, alleviate, and prevent the worst effects of mental illness and, what can we do to help those who suffer from mental illness regain their lives in such a way that the condition, like others, become merely another part of their history and their ongoing lives. And how might we best work together in our common enterprise: in the search for the best ways to be of assistance to individuals afflicted with conditions that are, commonly, catastrophic."

Jay Neugeboren, from his book, "Transforming Madness", page 120

<<<<<>>>>>

Vision

"That all individuals who have a mental illness have three main things: a safe place to live, a meaningful day to look forward to and adequate treatment options"

paraphrased from the Behavioral Health Region 3 Summit, Nov. 18,2010

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Mental Health Resource Guide Updated January 2012

TABLE OF CONTENTS

Mental Health Resource Guide Updated January 2012

What to Do and Where To Go In Case Of A EMERGENCY

Anyone who has a mental health or substance

abuse **emergency** can go at anytime to any

private or public hospital

anywhere in Georgia to be helped

It's state law!

*

Also, you can call for yourself or someone you know the toll-free number shown below to talk to a care consultant who will help you and if you wish, call the hospital where you want to go so when you go there, they will have information about you making it easier for them to help you.

GEORGIA CRISIS AND ACCESS LINE (GCAL)

1-800-715-4225

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Mental Health Resource Guide Updated January 2012

What to do and where to go in c as e o f a

Mental Health and/or Substance Abuse

If it's a…. **Non-Emergency**

What is a Non-Emergency?

If you or someone you know needs prompt but not immediate attention for a mental health or substance abuse problem

consider calling any one of the offices below. If you call the Georgia Crisis and Access Line (you do not have to be in a crisis to do so)

you can talk to a trained "care consultant" any time day or night who will help you decide what can be done to help. The counselor will

give you information that may be of immediate help and will make an appointment for you at a mental health/substance abuse recovery

center if appropriate.

Georgia Crisis & Access Line

It doesn't have to be an emergency to talk to a counselor!

Anyone anywhere in Georgia can call this number

It's a free service

800-715-4225

Hours: 24 hours a day, 7 days a week. No caller is turned away. Services: Hotline for emotional crisis, depression, suicide, abuse, family conflict, mental illness, and substance abuse crisis counseling. Crisis intervention visits in the community and evaluations are conducted by the mobile crisis team, crisis grief counseling for affected groups, support group for families of suicide victims and speakers' bureau and literature on suicide prevention.

DeKalb Community Service Board's Central Access Line 404-892-4646

(for assessments, scheduling appointments, referrals and crisis calls)

Trained counselors are available 24-hours a day, 7 days a week to speak to you or your client. A mobile crisis team is available within DeKalb County from 3:00pm to 11:00pm if needed. You may be referred to the Georgia Crisis and Access Line when you call this number.

Fulton County Department of Behavioral Health

404-613-3675

Hours: 8:30 AM to 5PM Mon-Fri

Any resident of Fulton County may call this number to make an appointment at any of the five (out of a total of 7 public; mental health centers in Fulton County that the Fulton County Department of Behavioral Health directly manages. There are two others in Fulton County. Grady Hospital's Auburn Avenue Recovery Center and North side Mental Health Outpatient Center. All five centers managed by Fulton County DBH have been or will be incorporated into "one-stop shops" that provide both mental health and physical health services in one location. You may call GCAL for advice but GCAL is not allowed to make mental health appointments at any of the five mental health centers supervised by the Fulton County Department of Public Health.

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Mental Health Resource Guide Updated January 2012

Suicide - Ask a Question, Save a Life

It is a myth that suicide cannot be prevented, It can be. The first step to preventing suicide is to question. Try to get the person in a private setting. If at the end of your questioning you are convinced the person is serious about ending his/her life, YOU MUST GET THEM HELP IMMEDIATELY! People who are thinking about suicide are not necessarily being irrational. They see suicide as a solution to their problems. It is important to make them realize there are other solutions, be prepared to offer solutions if you say they exists! Here are a few questions that may help you prevent suicide:

□□Do you ever feel hopeless? Feelings of hopelessness are often associated with suicidal thoughts.

□□Do you have thoughts of death? A "yes" response may indicate suicidal desires, but not necessarily suicidal plans. Many persons who are depressed say they think they'd be better off dead (dying in their sleep or being killed in an accident). Most will say they have no intention of killing self.

□□Do you have impulses or urges to kill yourself? A "yes" indicates active desire to die. This is a more serious situation.

□□Do you have actual plans to kill yourself? If "yes", then ask about specific plans, i.e. "how do you plan to do it?" Jumping? Pills? A gun? Hanging? "Have you obtained a rope?" "What building are you going to jump from?" Though these questions may sound gruesome, they may save a life. Danger is greatest when plans are clear and specific, and when method chosen is lethal.

□□Is there anything that would stop you, such as family or religious beliefs? If person feels others are better off without them have no deterrents, suicide is more likely.

□□Have you made suicide attempts in the past? Previous attempts indicate that future ones are more likely. Even if previous attempts did not seem serious, the next may be fatal, don't minimize previous attempts. All attempts should be taken seriously.

□□Would you be willing to talk to someone or ask for help? If the person is cooperative and has a plan for reaching out or is willing to accept help, the danger is less than if they are stubborn, secretive, hostile and unwilling to ask for help.

Other helpful questions are:

□□Do you ever wish you could go to sleep and never wake up?

□□Do you want to stop living?

Every year over 900 people in Georgia take their own lives. Suicide is a major, preventable public health problem. In 2006, it was the eleventh leading cause of death in the U.S., accounting for

33,300 deaths. The overall rate was 10.9 suicide deaths per 100,000 people. An estimated 12 to 25 attempted suicides occur for every suicide death.

For help finding treatment, support groups, medication information, help paying for your medications or other mental health-related services in your community, please contact the Georgia Crisis & Access Line at 1-800-715-4225.

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Mental Health Resource Guide Updated January 2012

Georgia Crisis & Access Line

www.mygcal.com

www.behavioralhealthlink.com

To get help with a mental health, drug or alcohol problem….

You do not need to be in an emergency to call this number. Anyone can call anytime

1-800-715-4225

Call 24 hours a day, 7 days a week

If you, or someone you know:

*Threatens to or talks about hurting or killing themselves

*Feels helpless

*Feels rage or uncontrolled anger

*Feels trapped like there is no way out

*Engages in reckless behaviors

*Increases alcohol or drug use

*Withdraws from friends and family

*Feels anxious, agitated, or unable to sleep

*Encounters dramatic mood changes

*Sees no reason for living

This is a free, confidential hotline that provides access to counseling and other services for preventing a crisis or getting through a crisis. Trained, caring professionals will help connect you to services in your area. They can even help you schedule appointments.

A crisis has no schedule. Wherever you live in Georgia, help is available; you don’t have to have an emergency to call. Speak to a trained counselor, not a recording. A mobile crisis team is available when needed.

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Mental Health Resource Guide Updated January 2012

DO’S AND DON’T WHEN HELPING SOMEONE WITH A MENTAL ILLNESS

DO'S

Remove yourself and others from threat of violence, and seek help

Try to establish a rapport, be careful not to come off as "phony"

Understand that the person may be terrified by experience of loss of control over thoughts and feelings

Remember that there is a person behind the symptoms of the illness

Treat the person with respect

Listen

Avoid belittling conversation, try not to speak in "baby talk", it's demeaning

Speak in simple sentences

Ask questions: you might save a life

□□Avoid direct, continuous eye contact or touching (can accelerate or encourage aggressive behavior)

DON'TS

□□Shout. If the person appears not to be listening it could be that other voices are interfering or predominating, not that the person is hard of hearing. If the person is shouting, make a point to lower your voice.

□□Criticize. It only makes matters worse, increases agitation

□□Bait the person into acting out, consequences could be tragic

□□Stand over the person. If he or she is seated, seat yourself

□□Attempt to transport the person if you perceive he/she may be dangerous

□□Block entry or exit, especially if the person is experiencing paranoia or agitation

□□Deny delusions or paranoid thoughts, they are "real" to the person experiencing them. Your denial could be perceived as calling the person a liar. Try instead to meet them where they are, i.e. "It must be frightening feeling that you are being followed" or "I understand how frustrating that must be for you." etc. You may also want to ask them "Have you always felt this way?" "When did you start to feel this way?" This line of questioning may be an effective lead-in to determine if the person has previously taken psychotropic medications. It is sometimes not a good idea to ask if someone is taking medications, or if they have been diagnosed with a mental illness. It may prove helpful to approach the issue by asking leading questions. The more psychotic the individual, the less likely your chances of success in getting answers:

□□Have you had your blood pressure checked recently?

□□Have you ever been checked for diabetes?

□□How is your appetite?

□□Do you take any type of medication? When is the last time you had it?

□□How have you been feeling lately? (depending on the answer…)

□□How long have you been feeling this way?

□□Why do you think you feel this way now?

□□Have you ever talked to a doctor about this?

□□Would you like to see a doctor?

□□Is there a family member or friend I can call?

It is helpful to listen for phrases like "stressed out", "nerves are shot", "nervous breakdown", "freaking out", "going off", "out of it", "under a lot of pressure" etc. Always ask "what do you mean by that?" or "could you explain that to me?"

The above information was contributed by NAMI Georgia

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Public Mental Health & Substance Abuse

Outpatient Centers in Fulton and DeKalb Counties

Do you, or someone you know experience these symptoms? *Feels helpless*Feels rage or uncontrolled anger *Feels trapped like there is no way out *Engages in reckless behaviors *increases alcohol or drug use *Withdraws from friends and family *Feels anxious, agitated, or unable to sleep *Encounters dramatic mood changes *Sees no reason for living *Threatens to or talks about hurting or killing themselves? If so, and it is an emergency, call 911 and while waiting for help, call the Georgia Crisis and Access Line (GCAL) 24 hours a day at 1-800-715-4225 and speak to a care consultant who will talk to you or the person you know who needs help. It is also important to know that anyone with a mental health emergency or substance abuse emergency can go to any public or private hospital for help 24 hours a day. Non-emergencies It does not

have to be an emergency to call GCAL. GCAL if you wish, can make an appointment at any public mental health outpatient center in Georgia. To get a mental health appointment almost anywhere in Georgia you can call the Georgia Crisis and Access Line (GCAL) at 1-800-715-4225 at anytime, day or night, 24/7. When you call this number you can talk to a trained "care consultant "who will offer help and make you an appointment at a mental health outpatient clinic. If you are in a crisis, the care consultant will suggest immediate action. If you have internet access, go to www.mygcal.com to search by zip code statewide for both mental health and substance abuse outpatient and residential treatment.

Fulton County Department of Behavioral Health, which manages five centers identified below that provide mental health and substance abuse services does not allow GCAL to make appointments for its five centers but does provide its own access line as shown below.

LISTED BELOW ARE ALL THE PUBLIC MENTAL HEALTH/SUBSTANCE ABUSE OUTPATIENT CENTERS IN FULTON COUNTY AND DEKALB COUNTY. THE GEORGIA CRISIS AND ACCESS LINE CAN PROVIDE YOU INFORMATION ABOUT ALL CENTERS THROUGHOUT GEORGIA.

PUBLIC MENTAL HEALTH OUTPATIENT CENTERS AND RELATED FACILITIES IN FULTON COUNTY

Grady Health System Outpatient Mental Health/Substance Abuse Programs-Intake, Community Based and Ongoing Service.

First. Adult Outpatient Services: Grady Health System offers a variety of mental health and/or substance abuse services to help meet your varied needs. These services range from intensive community based services offered in your home or place of housing, intensive day programming offered through our Psychosocial Rehabilitation Services (PSR), and group and individual therapy and medication management services at the Auburn Avenue Recovery Center (AARC).

To receive adult mental health and/or substance abuse outpatient services you must first have an assessment at our Intake center located at 48 Coca Cola Place (less than two blocks from the main entrance to Grady Hospital). You can schedule an Intake appointment by calling the Georgia Crisis and Access Line (GCAL) at 1-800-715-4225. Someone will be available to answer your call 24 hours a day, 7 days a week. If you prefer to walk-in without an appointment, the Intake program is open Monday-Friday at 8:00am. Availability to see you as a walk-in is limited and not guaranteed. Following your assessment at Intake, you will be referred to the ongoing outpatient services which meet your needs and preferences. The majority of these services are located in the Auburn Avenue Recovery Center at 250 Auburn Avenue. If you

are in need of services provided in your home or place of housing, you may be referred to our Community Outreach Services (COS).

You do not need to have a Grady card or go to the Grady Financial Counseling Office before receiving mental health or substance abuse services at Grady. You do not need to have a homeless shelter letter to be provided mental health or substance abuse services at Grady. If you have trouble completing the financial counseling process, our staff will assist you once you are getting the mental health or substance services you need. We promote overall health and wellness and it is important for everyone to get preventive and routine medical, dental and vision care. Grady's financial assistance program helps people get the care they need.

Child and Adolescent Outpatient Services: The child and adolescent outpatient program provides a range of in-clinic and outreach services including assessment, individual, group and family therapy for children and adolescents through ages 4-17. If you need information about scheduling an intake, please call 404-616-2215. At the time your intake is scheduled, the staff will advise you about what information and identification you will need to bring with you to your first appointment. The child and adolescent outpatient program is located on the 3rd floor of Piedmont

Hall at Grady Hospital, 81 Jesse Hill Jr. Drive, Atlanta, GA. Northside Mental Health Outpatient Center: 1140 Hammond Dr NE, Suite J-1075 Atlanta, GA 30328-5558 Atlanta, GA: (404) 851-8960 You can ask for an appointment for mental health counseling and/or an appointment for substance abuse treatment. You are allowed to call this center directly if you wish: 404/851-8950 Hours: 8:00 - 5:00 MON – THU You may call this center directly or call
the Georgia Crisis and Access Line 24/7 for an appointment.

Newport Integrated Behavioral Healthcare: 1810 Moseri Rd. Decatur, Georgia 30032 404-289-8223 just inside I-285 & just off Glenwood Ave. This is a private firm that contracts with the Georgia Department of Behavioral Health and Developmental Disabilities to serve among others, Fulton County residents who do not have insurance or very little or no income. You can call the Georgia Crisis and Access Line 24/7 to get an appointment or you can call Newport directly.

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5 more centers in Fulton County--Special Note

The five centers listed below are managed directly by the Fulton County Department of Behavioral Health. You cannot get an appointment at any of these five centers by calling GCAL. Instead, you can make appointments at any of the five centers located below by calling the Fulton County Behavioral Health Access & Information Line at 404-613-3675 between 8:30 AM and 5:00 PM, Monday-Friday or by calling or visiting anyone of the 5 centers. Fulton County Department of Behavioral Health is in the process of converting its mental health centers into one-stop-shop centers so more people can get a wide range of services with one stop..

Each of these centers is or will soon offer the following services:

1. Behavioral Health Care

2. Substance Abuse treatment

3. Nutrition Services

4. Dental Services

5. WIC

6. Workforce Development

7. Public Health

8. Primary Care At each center you can expect to receive: a. Individual Counseling b. Group Counseling C. Family Counseling d. Medication management e. Nursing Assessment f. Physician Assessment. For information about developmental disability services and child and adolescent services offered by Fulton County's Department of Behavioral Health, you may call the Fulton County Department of Behavioral Health's information and access line at 404-613-3675. Here are the five adult one-stop shops that provide mental health and substance abuse recovery assistance:

South Fulton Behavioral Health Center: 1636 Connally Drive East Point, GA 30344 Telephone: (404) 762-4042

West Fulton Behavioral Health Center: 475 Fairburn Road, SW Atlanta, GA 30331 Telephone: (404) 691-9627

Neighborhood Union Health Center: 186 Sunset Avenue, NW Atlanta, GA 30314 Telephone: (404) 612-4665

The Center for Health and Rehabilitation: 265 Boulevard, NE Atlanta, GA 30312 Telephone: (404) 730-1650 Fax: (404) 730-1651

Common Ground Health Center (North Fulton Service Center): 7741 Roswell Rd, Atlanta, Ga. 30350 Hours: 8 AM to 5 PM.

404-612-2273

PUBLIC MENTAL HEALTH OUTPATIENT CENTERS AND RELATED FACILITIES IN DEKALB COUNTY

The DeKalb County Community Service Board (CSB) provides two ways to make first time appointments at any of its three mental health outpatient centers: 1. By calling the Georgia Crisis and Access Line at 1-800-715-4225 or 2. By calling its own Central Access Line at 404-892-4646. Each of the three centers listed below provide adult and older psychological rehabilitation programs and child and adolescent mental health services.

North DeKalb Mental Health Outpatient Center—770-457-5867--3807 Clairmont Rd. N.E. Chamblee 30341

Clifton Springs Mental Health Outpatient Center: 404-243-9500--3110 Clifton Springs Rd. Suite B Decatur, Georgia 30034 HOURS:

8:15 am to 5:00 pm MON – FRI

Kirkwood Mental Health Outpatient Center: 404-370-7474 -- 23 Warren St. SE. Atlanta, Georgia 30317 HOURS: 8:15 am to 5:00 pm

MON – FRI

North DeKalb Mental Health Outpatient Center—770-457-5867--3807 Clairmont Rd. N.E. Chamblee 30341

Winn Way Mental Health Outpatient Center: 404-508-7770-- 445 Winn Way 4th Fl. Decatur, GA 30030 HOURS: 8:15 am to 5:00pm MON – FRI

DeKalb Regional Crisis Center—404-294-0499--450 Winn Way, Decatur 30030 provides outpatient crisis and interventions for DeKalb County, Fulton County and Clayton County residents. Services include psychiatric emergency treatment, a temporary observation unit and a stabilization unit.

DeKalb Addiction Clinic—404-508-6430--455 Winn Way, Decatur 30030 Provides comprehensive and intensive outpatient substance abuse treatment. Services that address the social, psychological, physical, and spiritual components of recovery through education, counseling, coping skills, and life skills development. through education, counseling, coping skills, and life skills development.

VETERANS' ADMINISTRATION MEDICAL CENTER--MENTAL HEALTH SERVICES

1670 Clairmont Rd, Ste. G, Box 29 Decatur, GA 404-321-6111 open 24/7 Services include: adult psychiatric inpatient, Mental health evaluations, psychiatric case management, alcoholism counseling, drug abuse counseling, inpatient alcoholism treatment for veterans with an honorable discharge. Need discharge papers.

ATLANTA VET CENTER

This center serves only veterans who have served in a combat zone of any war. It offers outpatient counseling. Address: 1440 Dutch Valley Place, Suite 1100, Box 55, Atlanta 30324. 404-347-7264 Hours: 8PM to 4:30 PM Mon-Fri.

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Questions to help determine if you may have a mental illness

Questions your doctor or a mental health professional might ask during a mental health assessment.

Mental illness has many faces, ranging from occasional episodes of depression to severe, chronic conditions like schizophrenia and bipolar disorder. Unlike broken bones that can be seen by an x-ray, the form of mental illness someone has can be hard to diagnose. It can also be hard to know how severe their condition might be. It is important to talk to a healthcare professional if you

believe that you or a loved one may be suffering from a mental illness. In order to determine if you are ill, a doctor might ask you many questions, such as these:

□□Do you have difficulty sleeping, either too much or too little?

□□Have you been sad or depressed for a long period of time?

□□Have your relationships with loved ones changed?

□□Do you ever do things without knowing why you did them?

□□Do you ever hear or see things that other people do not?

□□Have you ever thought of suicide?

□□Do you get nervous or angry easily?

□□Are you often anxious or afraid?

□□Do you drink a lot of alcohol or take street drugs?

If you can, let your first step be to talk to your doctor or a mental health professional.

You can call the **Georgia Crisis & Access Line--1-800-715-4225**-- right now to speak to a live care consultant free of charge and in total privacy. You can call this number 24 hours a day and get a mental health appointment anywhere in Georgia. You do not need to be in a crisis to call this number.

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Are you addicted to drugs or alcohol? Take this test to see.

Thanks to Helpline Georgia for permission to publish this

If you have doubts about whether or not you're an addict, take a few moments to read the questions below and answer them as honestly as you can.

□□Do you ever use alone?

□□Have you ever substituted one drug for another, thinking one particular drug was problem

□□Have you ever manipulated or lied to a doctor to obtain prescription drugs?

□□Have you ever stolen drugs or stolen money or property to obtain drugs?

□□Do you regularly use a drug when you wake up or when you go to bed?

□□Have you ever taken one drug to overcome the effects of another?

□□Do you avoid people or places that do not approve of you using drugs?

□□Have you ever used a drug without knowing what it was or what it would do to you?

□□Has your job or school performance ever suffered from the effects of your drug use?

□□Have you ever been arrested as a result of using drugs?

□□Have you ever lied about what or how much you use?

□□Do you put the purchase of drugs ahead of your financial responsibilities?

□□Have you ever tried to stop or control your using?

□□Have you ever been in a jail, a hospital, or a drug rehabilitation center because of your using?

□□Does using interfere with your sleeping or eating?

□□Does the thought of running out of drugs terrify you?

□□Do you feel it is impossible for you to live without drugs?

□□Do you ever question your own sanity?

□□Is your drug use making life at home unhappy?

□□Have you ever thought you couldn't fit in or have a good time without drugs?

□□Have you ever felt defensive, guilty, or ashamed about your using?

□□Do you think a lot about drugs?

□□Have you had irrational or indefinable fears?

□□Has using affected your sexual relationships?

□□Have you ever taken drugs you didn't prefer?

□□Have you ever used drugs because of emotional pain or stress?

□□Have you ever overdosed on any drug?

□□Do you continue to use despite negative consequences?

□□Do *you* think you might have a drug problem?

If you answered "yes" to some of the above questions, you may want to seek further evaluation.

Do you want help right now?

You can call the ***Georgia Crisis & Access Line- 1-800-715-4225*** at any time, day or night and talk to a trained care consultant will help you determine if you need to seek treatment for your problem with substance abuse. The consultant can provide the names of all the public mental health outpatient centers in Fulton and DeKalb Counties as well as the public outpatient addiction centers, all of which also offer substance abuse treatment, as well as mental health Issues.

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Mental Illness Basics

http://www.webmd.com

What is mental illness? Mental illness is any disease or condition affecting the brain that influence the way a person thinks, feels, behaves and/or relates to others and to his or her surroundings. Although the symptoms of mental illness can vary from mild to severe and are different depending on the type of mental illness, a person with an untreated mental illness often is unable to cope with life's daily routines and demands.

What causes mental illness? Although the exact cause of most mental illnesses is not known, it is becoming clear through research that many

of these conditions are caused by a combination of genetic, biological, psychological and environmental factors. One thing is for sure – mental illness is not the result of personal

weakness, a character defect or poor upbringing, and recovery from a mental illness is not simply a matter of will and self-discipline.

Heredity (genetics): Many mental illnesses run in families, suggesting that the illnesses may be passed on from parents to children through genes. Genes contain instructions for the function of each cell in the body and are responsible for how we look, act, think, etc. But, just because your mother or father may have a mental illness doesn't mean you will have one. Hereditary just means that you are more likely to get the condition than if you didn't have an affected family member. Experts believe that many mental conditions are linked to problems in multiple genes -- not just one, as with many diseases -- which is why a person inherits a susceptibility to a mental disorder, but doesn't always develop the condition. The disorder itself occurs from the interaction of these genes and other factors -- such as psychological trauma and environmental stressors -- which can influence, or trigger, the illness in a person who has inherited a susceptibility to it.

Biology: Some mental illnesses have been linked to an abnormal balance of special chemicals in the brain called neurotransmitters.

Neurotransmitters help nerve cells in the brain communicate with each other. If these chemicals are out of balance or are not working properly, messages may not make it through the brain correctly, leading to symptoms of mental illness. In addition, defects in or injury to certain areas of the brain also have been linked to some mental conditions.

Psychological trauma: Some mental illnesses may be triggered by psychological trauma suffered as a child, such as severe emotional, physical or sexual abuse; a significant early loss, such as the loss of a parent; and neglect.

Environmental stressors: Certain stressors -- such as a death or divorce, a dysfunctional family life, changing jobs or schools and substance abuse -- can trigger a disorder in a person who may be at risk for developing a mental illness

Can Mental Illness Be Prevented? Unfortunately, most mental illnesses are caused by a combination of factors and cannot be prevented.

How Common Is Mental Illness? Mental illnesses are very common. In fact, they are more common than cancer, diabetes or heart disease.

According to the U.S. Surgeon General, an estimated 23% of American adults (those ages 18 and older) -- about 44 million people -- and about 20% of American children suffer from a mental disorder during a given year. Further, about 5 million Americans adults, and more than 5 million children and adolescents suffer from a serious mental condition (one that significantly interferes with functioning).

Depression Sometimes physical problems can cause depression. But other times, symptoms of depression are part of a more complex psychiatric problem. There are several different types of depression, including: Major depressive disorder, Dysthymia, Seasonal affective disorder, Psychotic depression and bipolar depression

Major Depression--An individual with major depression, or major depressive disorder, feels a profound and constant sense of hopelessness and despair. Major depression is marked by a combination of symptoms that interfere with the person's ability to work, study, sleep, eat, and enjoy once pleasurable activities. Major depression may occur only once but more commonly occurs several times in a lifetime. ***What Are the Symptoms of Major Depression?*** Symptoms of depression include: Sadness, Irritability, loss of interest in activities once enjoyed, withdrawal from social activities and Inability to concentrate.

Bipolar Disorder--Bipolar depression, also called bipolar disorder or "manic-depressive" disease, is a mental illness that causes people to have severe high and low moods. People who have this illness switch from feeling overly happy and joyful to feeling very sad, and vice versa. Because of the highs and the lows -- or two poles of mood -- the condition is referred to as

"bipolar" depression. In between episodes of mood swings, a person may experience normal moods. The word "manic" describes the periods when the person feels overly excited and confident. These feelings can quickly turn to confusion, irritability, anger, and even rage. The word "depressive" describes the periods when the person feels very sad or depressed. Because the symptoms are similar, sometimes people with bipolar depression are incorrectly diagnosed as having major depression. Most individuals with bipolar disorder spend more time in depressed phases than in manic phases.

What Are the Symptoms of Bipolar Disorder? The dramatic and rapidly changing mood swings from highs to lows do not follow a set pattern, and depression does not always follow manic phases. A person may also experience the same mood state several times before suddenly experiencing the opposite mood. Mood swings can happen over a period of weeks, months, and sometimes even years. The severity of the depressive and manic phases can differ from person to person and in the same person at different times.

Schizophrenia--Schizophrenia is a serious brain disorder that distorts the way a person thinks, acts, expresses emotions, perceives reality and relates to others. People with schizophrenia -- the most chronic and disabling of the major mental illnesses -- often have problems functioning in society, at work and at school, and in relationships. Schizophrenia can leave its sufferer frightened and withdrawn. It is a life-long disease that cannot be cured, but usually can be controlled with proper treatment. Contrary to popular belief, schizophrenia is not a split personality. Schizophrenia is a psychosis, a type of mental illness in which a person cannot tell what is real from what is imagined. At times, people with psychotic disorders lose touch with reality. The world may seem like a jumble of confusing thoughts, images and sounds. The behavior of people with schizophrenia may be very strange and even shocking. A sudden change in personality and behavior, which occurs when people lose touch with reality, is called a

psychotic episode.

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Why are so many people with a serious mental illness homeless?

http://www.nrchmi.samhsa.gov/facts

http://www.mentalhealth.samhsa.gov/cmhs/Homelessness/

2 - 3 million individuals are affected by homelessness each year in the United States. For most people, homelessness is a short, one-time event. But a relatively small and visible group experiences homelessness repeatedly or for long periods and places heavy demands on available assistance. For people with severe mental illnesses, home can be a space to live in dignity and move toward recovery. Providing adequate housing for individuals with mental illnesses

requires support services and access programs, such as those provided via the U.S. Department of Health and Human Services and the Department of Housing and Urban Development.

As many as 700,000 Americans are homeless on any given night. An estimated 20 to 25 percent of these people have a serious mental illness, and one-half of this subgroup also has an alcohol and/or drug problem. Minorities, especially African Americans, are over-represented among homeless persons with mental illness.

The Center for Mental Health Services (CMHS) supports programs to assist people with mental illnesses who are homeless in obtaining treatment and other services such as

primary health care, substance abuse treatment, legal assistance, entitlements, and other supports, while making the transition from homelessness. CMHS develops models for programs to deliver mental health services to people who are homeless with severe mental illnesses and provides funding to States to deliver support services.

MENTAL HEALTH

CASE MANAGEMENT SERVICES

Saint Joseph's Mercy Care Service

Services: include linkage to community mental health, substance abuse services, medical services, services, referrals and continuing assistance with emergency, transitional, supportive, and permanent housing, residential drug and alcohol programs, employment, financial/mainstream benefits and legal needs. Who is eligible:

Individual must have a suspected mental illness and be currently homeless to qualify for help. Where to go for help: Main office 424 Decatur St. Atlanta, Ga. 30312 Monday-Friday 8:30am-5:00 pm 678-843-8500

Mercy Clinic at the Gateway 24/7 275 Pryor St., Atlanta, Ga. 30303 Monday-Friday 9:00am-4:00pm 678-843-8840 Mercy Clinic at St. Luke's 420 Courtland Street. NE Atlanta, Ga. 30308 Mon & Wed only 9:30am-4:00 pm 678-843-8870 *you are encouraged to call first for an appointment and to confirm hours. Walk-ins are accepted on a first come/first served basis and based on case manager's availability.

www.stjosephsatlanta.org

Jewish Family & Career Services

Located at the Gateway Center at 275 Pryor Street NW, Atlanta, GA 30303

Main office number is 770-677-0474.

Contact Person: Angelique Lawson, 404-215-6637

Community Advanced Practice Nurses, Inc. (CAPN) Mental Health Clinic

Services: include counseling and therapy; Eligibility: adult women who are homeless

458 Ponce de Leon Ave. Atlanta, GA. 30306 404-815-1811 Hours: Tuesday, Wednesday and Friday

Note: CAPN offers counseling and therapy for children at their CAPN Physical Health Clinic at 173 Boulevard

NE, Atlanta 30312, 404-658-1500 Call for hours the Physical Health Clinic is open as hours vary.

Atlanta Day Shelter for Women and Children

Services: mental health counseling Who is eligible: homeless women and children

Various mental health providers visit the day shelter so it is best to call first to confirm when a mental health counselor will be present.

655 Ethel St. NW Atlanta 30318 Hours: Monday-Saturday 8 am to 4 am Sunday 10 AM to 4 PM

404-876-2894

Community Friendship Inc.

85 Renaissance Pkwy., NE Atlanta, GA 30308 (404)875-0381 SERVICE HOURS: Day program: 9:00 am to 2:00 pm MON - FRI; all other services: 8:30 am to 5:00 pm MON - FRI; noon to 3:00 pm SAT

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Check List

For helping individuals with a mental illness

This checklist may help insure that the most commonly needed services are not overlooked.

Name _____

Social security # _____

NEED?

____ mailing address—

Crossroads (404-873-7650) First Presbyterian 404-228-7746

____ Mental health treatment: counseling and medications—call GCAL 24/7 at 1-800-715-4225—its easy. Call anytime day or night to talk to a care consultant free of charge and get an appointment for outpatient mental health and/or substance abuse treatment—all free if you are have no income.

____ Mental health case management--call United Way at 211 or 404-614-1000

____ Food stamps---apply at Dept. of Family and Children's Services (DFCS) offices

____ SSI/SSDI disability application and related appointments,: First Step at 404-577-3392 or call Social Security at 1-800-772-

1213 from 7am-7pm M-F to get an appointment to go into their office, apply online or apply by telephone.

____ General assistance—applying at DFCS office for this assistance while awaiting decision on SSI/SSDI disability

application (DFCS)—two requirements: prove an SSI or SSDI claim has been filed and obtain doctor's statement

____ Shelter, Transitional Shelters, Transitional

____Housing visit or call Gateway at 404-215-6600 275 Pryor St. at Memorial Dr.

____ Permanent housing--call United Way at 211 or 404-614-1000 24 hours a day 7 days a week

____ Physical Health Care--Grady Hospital at 80 Butler St., Mercy Mobile (call 404/880-3600 for locations) and others.

____ Drug/alcohol recovery programs--call Gateway Center at 404-215-6600 or United Way at 211 (or 404-614-1000) for info.

____ Vocational Rehab/Employment--call the GA Dept. of Vocational Rehab at 404-261-8600

____ ID & Birth Certificates & ID--Places that help with ID: Crossroads: (404-873-7650) Central Presbyterian: (404-659-7119)

____ Clothing--call United Way (211 or 404-614-1000)

____Transportation assistance--call United Way-at 211 or 404-614-1000

____Legal services--Atlanta Legal Aid at 404-524-5811, GA Law Center for Homeless at 404-681-0680

____Other_____

_____

Links to Mental Health Organizations

These web sites are excellent for learning more about mental health issues. Some of these agencies also offer services in Atlanta.

Local and State

Behavioral Health Service Coalition--BHSC is a statewide collaboration of public and private individuals and organizations which educates and shares information, among our members, the public and policy-makers and coordinates advocacy. The coalition holds meetings in Atlanta every second Monday of each month and sponsors two events each year: the Candlelight Ceremony and

Mental Health Day at the Capitol. For more information and membership, contact Rheba Smith at rheba.smith@gpsn.org. All meetings are held at the Skyland Trail Fuqua Center at 1931 North Druid Hills Road, Atlanta. The address of the BHSC is 1381 Metropolitan Parkway | Atlanta | GA | 30310

Community Health

Community Friendship, Inc. (CFI) www.commfriend.com 75 Renaissance Parkway, Atlanta 30308 404-875-0381 Provides a wide range of supportive housing in multiple locations for men and women who are chronically homeless and who have a chronic mental illness so they can develop living, learning, working and social skills and access the resources needed to lead successful and satisfying lives.

Coalition for Homeless People with a Mental Illness—Atlanta www.homelessmentallyill.org 2026 Dellwood Dr. Atlanta. Ga. 30309 404-351-3225 This coalition is composed of volunteers, homeless service providers, advocates, government agencies, volunteers, just anyone else who is interested in improving the delivery of critically needed services to homeless people with a mental illness. They meet every 3rd Wednesday to address a wide range of topics that directly or indirectly affect Atlanta's homeless men and women. Key contact is Alan Harris.

Georgia Advocacy Office (GAO) 404-885-1234 www.thegao.org The Georgia Advocacy Office is a private non-profit corporation.

Its mission is to work with and for oppressed and vulnerable individuals in Georgia who are labeled as disabled or mentally ill to secure their protection and advocacy. GAO's work is mandated by Congress, and GAO has been designated by Georgia as the agency to implement Protection and Advocacy within the state. Its main priority is standing beside people in stopping abuse.

Georgia Department of Behavioral Health and Developmental Disabilities(DBHDD)—provides treatment and support services to people with a mental illness and addictive

diseases and support to people with mental retardation and related developmental disabilities. DHBDD serves people of all ages with the most severe and like to be long-term conditions.

Georgia.

Georgia Mental Health Network--www.mcg.edu/resources/mh/index.html for additional mental health services and resources in Georgia (Medical College of Georgia)

FaithWorks –www,FaithWorks.org—Mission is to target the faith community hoping to educate and engage clergy and lay leaders under the FaithWorks banner. And, lead the way toward a better quality of life for those with mental and/or addictive illnesses and their families. This will be done by educating, innovating and championing effective solutions to intractable problems.

Mental Health Consumer Network-- 246 Sycamore St. Decatur 30030 404/687/9487 www.gmhcn.org The Consumer Network is a Georgia non-profit corporation founded in 1991 by consumers of state services for mental health, developmental disabilities, and addictive diseases. It hosts one of the largest statewide annual consumer conventions in the nation. The corporation evolved from a meeting of 30 consumer leaders held in Tucker, Georgia in October of 1990. And now has grown to over 3700 members across the state Mental Health America of Georgia--www.mhageorgia.org 100 Edgewood Ave. Atlanta 30303 404-527-7175 MHA is the merger of two advocacy and service provision agencies. Formerly called the National Mental Health Association of Georgia, it is a leading voice in advocacy across the state working at the individual and system level to ensure that Georgians obtain access to best practice level mental health services

statewide. A primary goal of Mental Health America is to educate the general public about the realities of mental health and mental illness. Behavioral Health Service Coalition--BHSC is a statewide collaboration of public and private individuals and organizations which educates and shares information, among our members, the public and policy-makers and coordinates advocacy in behalf of individuals who have a mental illness, an addiction to drugs/alcohol or both. The Coalition holds monthly meetings in Atlanta at noon every second Monday and sponsors two events each year: the Candlelight Ceremony and Mental Health Day at the Capitol. For more information and membership, contact Rheba Smith at rheba.smith@gpsn.org

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National Alliance For The Mentally Ill of Georgia (NAMI): 3050 Presidential Drive, Suite 202, Atlanta, GA 30340, 770-234-0855

or 800-728-1052.

This is a nonprofit, grassroots, self-help, support and advocacy Organization of consumers, families and friends of people with brain disorders (mental illness), such as schizophrenia, major depression, bipolar disorder, obsessive-compulsive disorder, anxiety disorders, etc. Founded in 1979, NAMI has more than 225,000 members and 1200 state and local affiliates that seek equitable services for

people with mental illness NAMI Georgia has 32 local affiliates with 1200 members. Working on the national, state, and local levels,

NAMI supports increased funding for research, and advocates for adequate health insurance, housing, rehabilitation, and

employment for people with psychiatric illnesses. NAMI also provides education about brain disorders. The Family-to-Family

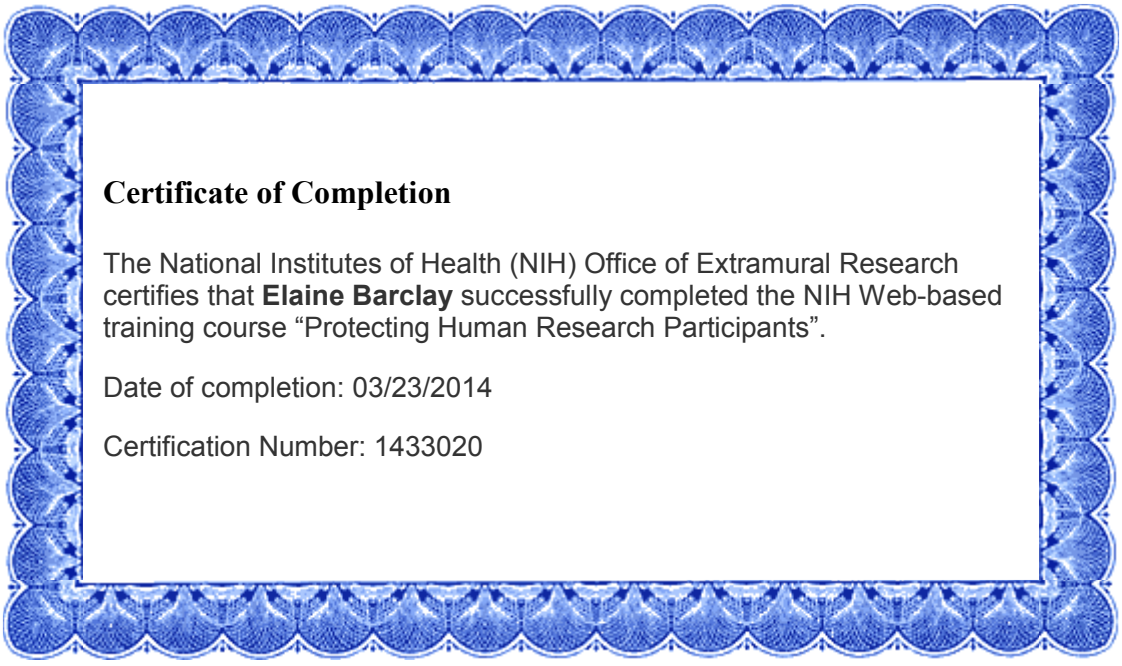
Education Program is offered at no cost to participants. NAMI works with the Governor, the Legislators, the Department of Human

Resources, other State Agencies, and other mental health advocacy groups. We continually strengthen and develop our relationships

with these organizations to improve the system of care in Georgia. See the"Advocacy" page for further information. NAMI has

outreach programs that range from 30 minute presentations for general audiences to a 40 hour training course for Law Enforcement.

Appendix E: NIH Certification of Completion



Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Elaine Barclay** successfully completed the NIH Web-based training course “Protecting Human Research Participants”.

Date of completion: 03/23/2014

Certification Number: 1433020

Appendix F: Letter of Informed Consent

Researcher: Elaine M. Barclay

You are invited to take part in a research study designed to understand the experiences and perceptions of Domestic Violence Facilitators'. This study is being conducted by Elaine M.Barclay, who is a doctoral candidate at Walden University. I am not an employee of this DV organization, therefore eliminating potential conflicts of interest.

Background Information:

The purpose of this study is to address the problem of DV facilitators' administering the same treatment program to repeat offending males without any signs of rehabilitation, by exploring the lived experiences of DV facilitators'.

Inclusion Criteria:

If your qualifications meet the criterion for this study, 1would greatly appreciate it if you would participate in a 30-60 minute interviewing process to elaborate on the core for this research study. Also, in order to participate in the research study, you must meet the following eligibility requirements:

Be at least 18 years old

Proficient English speaking

Actively facilitating DV treatment programs to repeat offending males

Must be employed with this DV organization

Procedures:

If you agree to this study, you will be asked to:

• Call the telephone number listed on the posted flyer on the bulletin boards for the 15-minute screening process. Upon passing the screening process, either a face-to-face, or telephone interview using FreeConferenceCall will be scheduled. Entire interview will be approximately 30-60 minutes.

• Agree to email "I consent," to elaine.barclay@waldenu.edu , to document you agree to participate in the research study.

• All interviews will be audio recorded and filed in a fire proof filing cabinet for 5 years. [will be the only individual that will have a set of keys.

Voluntary Nature of the **Study:**

Your participation in this study is voluntary and you can withdraw at any time without penalty or negative consequences. If you decide to participate, you are not required to answer any question that you consider to be too personal.

Risks and Benefits:

Participating in this study involves some risks that may involve minor discomforts that can be encountered in daily life, such as stress, fatigue, or possibly frustration. However, I assess that no harm will come to your health or safety. If you meet the inclusion criterion, this will serve as justifying and minimizing your vulnerary.

The outcomes of this study are expected to benefit the field of human services and have a positive effect on society. This study will also benefit by providing social change by bringing

awareness of the life expectancies and challenges of DV facilitators administering treatment programs to repeat offending males.

I am a licensed Associate Professional Counselor, National Certified Counselor, Human Service Certified Practitioner. This aligns with Human Service Code of Ethics of being a mandated reporter of reporting those that pose a harm to self and others.

Compensation:

There will not be compensation for this study.

Confidentiality:

All information you provide will be kept confidential and I will not use your personal information for any purposes outside of this research project. Also, I will not include your name or anything else that could identify you in the study reports. Identifiers will be obtained to protect your identity. Data will be protected in a password protected electronic folder and in a locked file cabinet. Consent sent via email will be protected by a password-protected computer and will remain confidential. Only I will have access to the data and your identity will be protected as an identification code will be assigned to your responses. Your responses will be stored and kept for a period of at least 5 years, as required by Walden University.

Person to Contact:

You may ask questions you have now. Or, if you have questions later, you may contact the researcher via email at elaine.barclay@waldenu.edu. If you want to speak privately about your rights as a participant, you can call 1-800-925-3368 ext. 312-1210. Walden University's approval number for this study is 08-29-16-0427800 and it expires on August 28, 2017.

Please print or save a copy of this form for your records.

Statement of Consent:

If you feel you understand the study well enough to make a decision about your participation, please indicate your consent by replying to this email with the words, "I consent" in the body of your email.

Thank you,

Elaine M. Barclay

Elaine.barclay@waldenu.edu

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